

# **Supplementary Prescribing by Nurses, Pharmacists, Chiropodists/Podiatrists, Physiotherapists and Radiographers within the NHS in England**

## **A guide for implementation**

*Department of Health*  
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For action/information	<p>NHS Trusts - Chief Executives  NHS Trusts - Directors of Nursing  NHS Trusts – Chief Pharmacists  NHS Trusts – AHP Leads  NHS Foundation Trusts – Chief Executives  NHS Foundation Trusts – Directors of Nursing  NHS Foundation Trusts – Chief Pharmacists  NHS Foundation Trusts – AHP Leads  PCT - Chief Executives  PCT - Lead Nurses  PCT – AHP Leads  PCT – Pharmaceutical Advisors  PCT – Prescribing Leads  PCT – Prescribing Chairs  Prison – Pharmacy Leads  General Practitioners – GMS, PMS and APMS contractors (one per practice)  NHS Walk-in Centre Managers  Strategic Health Authorities - Chief Executives  Workforce Development Directorates / Workforce Development Confederations – Chief Executives, Chief Nurses, Pharmaceutical Advisors, Non-Medical Prescribing and AHP Leads  Strategic Health Authorities - Chief Nurses, Pharmacy Leads and AHP Leads  Community Pharmacies (one per pharmacy)</p>
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## ***DEPARTMENT OF HEALTH***

### **HOW TO USE THE GUIDE**

This guide has been prepared for:

- NHS Trusts
- Foundation Trusts (For information only)
- Primary Care Trusts
- Strategic Health Authorities
- Personal Medical Services
- General Medical Practices
- General Practitioners
- NHS Walk-in Centres
- Community, Hospital and Primary Care Pharmacists
- Prison Pharmacy Leads
- PCT Pharmaceutical Advisors
- Strategic Health Authority Workforce Development Directorates / Workforce Development Confederations
- SHA Prescribing Leads
- SHA Pharmacy Leads
- Higher Educational Institutions (HEIs) providing nurse and AHP education
- Schools of Pharmacy and other HEIs providing pharmacy education
- Managers of Services
- Supplementary prescribers and healthcare practitioners training as supplementary prescribers
- Carer and user groups

This guide for implementation was first produced in 2003 to assist implementation of supplementary prescribing for nurses and pharmacists. Changes to NHS regulations in April 2005 have enabled three other professions, namely chiropodists/podiatrists, physiotherapists and radiographers to be able to train as supplementary prescribers. The Department of Health has therefore taken this opportunity to update the Guide.

It will be for Primary Care Trusts, NHS Trusts and Workforce Development Directorates / Workforce Development Confederations to consider, in light of patient and service need and local priorities, which nurses, pharmacists, chiropodists/podiatrists, physiotherapists and radiographers in their area should undertake training and preparation for supplementary prescribing and are funded to do so. This guide has been prepared to assist them. Copies of all or part of the guide may be reproduced at local level as required in order to meet local need and to improve the patient experience.

The guide will also be of interest to the Prison Healthcare Service, the Defence Medical Services and the independent healthcare sector.

It can be found on the Department's website

[www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/SupplementaryPrescribing/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/SupplementaryPrescribing/fs/en) . The website contains other detailed information on the prescribing

and supply of medicines by nurses, pharmacists, chiropodists/podiatrists, physiotherapists and radiographers and will be kept up to date on future developments.

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## **Introduction**

1. This guide sets out the administrative and procedural steps needed to enable the following professions to act as supplementary prescribers:
  - Registered nurses
  - Registered midwives
  - Registered pharmacists
  - Registered chiropodists/podiatrists
  - Registered physiotherapists
  - Registered radiographers
  
2. It also provides advice on good practice for supplementary prescribers and their independent prescriber partner (doctor or dentist). The guide applies to all the professions listed above. **[NB Where the term “nurse” is used in this document it includes Registered Midwives and Health Visitors. Where the term “AHPs” is used, it refers to those Allied Health Professions currently able to train as supplementary prescribers i.e. chiropodists/ podiatrists, physiotherapists and radiographers.]**

### *Scope of this guidance and effect of devolution*

3. This guide sets out the steps required to implement supplementary prescribing in England. Medicines legislation permits the introduction of supplementary prescribing across the UK, but it is for the devolved administrations in Scotland, Wales and Northern Ireland to decide whether and how it is implemented for the NHS in their countries.

## **Background**

### *General*

4. Supplementary prescribing has its basis in the recommendations of the final report of the Review of Prescribing, Supply and Administration of Medicines (1999), which recommended that two types of prescriber should be recognised:

- the independent prescriber who would be responsible for the assessment of patients with undiagnosed conditions and for decisions about the clinical management required, including prescribing.
- the dependent prescriber who would be responsible for the continuing care of patients who have been clinically assessed by an independent prescriber. This continuing care might include prescribing, which would usually be informed by clinical guidelines and be consistent with individual treatment plans, or continuing established treatments by issuing repeat prescriptions, with the authority to adjust the dose or dosage form according to the patients' needs. The Review recommended that there should be provision for regular clinical review by the assessing clinician.

**[Note: the previous term Dependent Prescriber is now referred to as a Supplementary Prescriber]**

5. In a press release on 4 May 2001, Department of Health Ministers announced the Government's intention to take steps to allow supplementary prescribing by nurses and prescribing by other professions such as pharmacists following the enactment of the Health and Social Care Bill (see also paragraph 9). Ministers subsequently decided that initially, the greatest benefit to the NHS and to patients would be the introduction of supplementary prescribing by nurses and pharmacists, following diagnosis by a doctor.
6. In late 2001 and early 2002, DH officials undertook a series of informal consultation meetings on supplementary prescribing with representatives of the medical, pharmacy and nursing professions. This was followed by a formal joint consultation by the Department of Health and the then Medicines Control Agency between April and July 2002. The results of the consultation were considered at meetings of the Committee on Safety of Medicines and the Medicines Commission in September 2002. Their recommendations were considered by Ministers, and the Department of Health's plans were set out in a press release in November 2002. Amendments to relevant legislation enabled the introduction of supplementary prescribing for first level registered nurses, registered midwives and registered pharmacists from April 2003.
7. In late 2003 and early 2004 DH officials undertook a series of informal consultation meetings on proposals to extend supplementary prescribing to chiropodists/podiatrists, physiotherapists, radiographers (AHPs) and optometrists with representatives of these

professions. This was followed by a formal joint consultation by the Department of Health and the Medicines and Healthcare products Regulatory Agency (MHRA) between May and August 2004. The results of the consultation were considered at meetings of the Committee on Safety of Medicines and the Medicines Commission in October 2004. Their recommendations were agreed by Ministers. Changes to regulations in April 2005 have enabled AHPs from these three professions to be eligible to train as supplementary prescribers. Changes to regulations to enable optometrists to be able to train and register as supplementary prescribers are expected in late summer 2005.

#### *What is supplementary prescribing?*

8. The working definition of supplementary prescribing is “a voluntary partnership between an independent prescriber (a doctor or dentist) and a supplementary prescriber to implement an agreed patient-specific Clinical Management Plan with the patient’s agreement”.

#### *Legal basis of supplementary prescribing*

9. Section 63 of the Health and Social Care Act 2001 enabled the Government to extend prescribing responsibilities to other health professions. It also enabled the introduction of new types of prescriber, including the concept of a supplementary prescriber, by allowing Ministers by Order to attach conditions to their prescribing. Section 42 (for England and Wales) and Section 44 (Scotland) also relate to dispensing by community pharmacists of prescriptions written by these new prescribers. Provisions in Northern Ireland are a matter for relevant NI legislation. Amendments to the Prescription Only Medicines Order and NHS regulations allowed supplementary prescribing by suitably trained nurses and pharmacists from April 2003. Amendments to the Prescription Only Medicines Order and NHS regulations in April 2005 now allow supplementary prescribing by suitably trained chiropodists/podiatrists, physiotherapists and radiographers.

### *Aims of supplementary prescribing*

10. Supplementary prescribing is intended to provide patients with quicker and more efficient access to medicines, and to make the best use of the clinical skills of eligible professionals. Over time, supplementary prescribing is also likely to reduce doctors' workloads, freeing up their time to concentrate on patients with more complicated conditions and more complex treatments. Time spent initially developing a simple Clinical Management Plan, should be time saved when the patient returns for review to the supplementary prescriber rather than the doctor.

### *Comparison with independent nurse prescribing and with Patient Group Directions*

11. Following training incorporated into their specialist practitioner programmes, District Nurse and Health Visitor independent prescribers can prescribe from the Nurse Prescribers' Formulary for District Nurses and Health Visitors: this comprises a limited list of medicines and a large number of dressings and appliances relevant to community nursing and health visiting practice.
12. "Extended Formulary" independent nurse prescribers undertake a longer, specific programme of preparation and training, and can prescribe from the Nurse Prescribers' Extended Formulary. The Extended Formulary currently comprises around 240 Prescription Only Medicines (POMs) to treat 112 medical conditions (plus all relevant Pharmacy (P) & General Sales List (GSL) medicines for these conditions).
13. Patient Group Directions are written instructions for the supply and/or administration of medicines to groups of patients *who may not be individually identified before presentation for treatment*. The Department has always made it clear that the majority of clinical care should be provided on an individual, patient-specific basis. Consequently the supply and administration of medicines under Patient Group Directions should be reserved for those situations where this offers an advantage for patient care (without compromising patient safety), and where it is consistent with appropriate professional relationships and accountability. Further detail is set out in HSC 2000/026 Patient Group Directions (England Only). The National Prescribing Centre has also produced helpful guidance entitled "Patient Group Directions – A practical guide and framework of

competencies for all professionals using patient group directions”. This is available on their website at [www.npc.co.uk](http://www.npc.co.uk)

14. Supplementary prescribers prescribe in partnership with a doctor or dentist (the independent prescriber). Nurse and pharmacist supplementary prescribers are able to prescribe any medicine including controlled drugs and unlicensed medicines that are listed in an agreed Clinical Management Plan. Amendments to ‘The Misuse of Drugs Regulations 2001’ and to GMS/PMS regulations to enable prescribing of controlled drugs by supplementary prescribers (nurses and pharmacists) came into effect on 14 April 2005. AHPs are able to prescribe all medicines (including unlicensed medicines), with the current exception of Controlled Drugs. All supplementary prescribers may prescribe for the full range of medical conditions, provided that they do so under the terms of a patient-specific Clinical Management Plan (CMP). **The Plan will be drawn up, with the patient’s agreement, following diagnosis of the patient by the independent prescriber and following consultation and agreement between the independent and supplementary prescribers.**

### **How supplementary prescribing will work**

#### *General principles*

15. The independent prescriber **must** be a doctor or dentist. It is for the independent prescriber in discussion with the supplementary prescriber, to determine which patients may benefit from supplementary prescribing and the medicines that may be prescribed by the supplementary prescriber under the Clinical Management Plan (CMP). S/he will clearly need to take account of the professional relationship between themselves and the supplementary prescriber as well as the experience and areas and degree of expertise of the supplementary prescriber when coming to a decision.
16. Supplementary prescribing is a partnership between the independent and the supplementary prescriber, who between them should draw up and agree an individual CMP for the patient’s condition before supplementary prescribing begins. Two sample draft templates, available on the DH supplementary prescribing website ([www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/SupplementaryPrescribing/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/SupplementaryPrescribing/fs/en)) and also attached as Annexes C and D to this guide

should help with this. The templates have been produced to help the NHS to develop CMPs more easily. Different parts of the NHS have “tested” these templates in practice. The use of these templates is not mandatory. They can also be adapted/amended to suit local needs, or in some cases, it may be appropriate to develop CMPs from scratch. But there **must** be an individual CMP. Detailed information on what should be included in the CMP is set out in paragraph 55.

17. In each case the independent and/or supplementary prescriber should obtain the patient’s agreement to supplementary prescribing taking place and then discuss and agree the CMP for that particular patient. The independent and supplementary prescribers must maintain communication on an ad-hoc basis while the supplementary prescriber is reviewing and prescribing for the patient. They should ideally jointly carry out a formal clinical review at the agreed time – normally within a maximum of 12 months of the start of the CMP. (Periods longer than 12 months between joint clinical reviews or reviews by the independent prescriber may occasionally be acceptable in the CMP where the patient’s condition has been shown to be stable and deterioration of the condition is not expected during a period longer than 12 months. The appropriateness of such a longer period between joint or independent prescriber clinical reviews is the responsibility of the independent prescriber though it must be agreed with the supplementary prescriber). If a joint clinical review is not possible, the outcome of the clinical review by the independent prescriber needs to be discussed with the supplementary prescriber, who must agree continuation of, or changes to, the CMP.
  
18. The independent prescriber should be the clinician responsible for the individual’s care at the time that supplementary prescribing is to start. If this responsibility moves from one independent prescriber to another (for example from the patient’s GP to a hospital consultant, or from one GP to another), the supplementary prescriber may **not** continue to prescribe, unless he \ she negotiates and records in the patient record a new agreement to enter a prescribing partnership with the new independent prescriber. Supplementary prescribing partnerships involving more than one independent prescriber (eg shared care arrangements) are referred to in paragraph 24.

## *Characteristics of Supplementary Prescribing*

19. The key characteristics of supplementary prescribing are:

- Supplementary prescribing may only take place after a specified point in the individual patient episode, i.e. after assessment and diagnosis by an independent prescriber and the development of a written CMP agreed between the independent and supplementary prescriber.
- The independent prescriber is responsible for the diagnosis and setting the parameters of the CMP, although they need not personally draw it up. (The parameters should be agreed between the independent prescriber and the supplementary prescriber).
- The supplementary prescriber has discretion in the choice of dosage, frequency, product and other variables in relation to medicines only within the limits specified by the CMP. The Plan may include reference to recognised and authoritative clinical guidelines and guidance (local or national), whether written or electronic, as an alternative to listing medicines individually. Any guidelines referred to should be readily accessible to the supplementary prescriber when managing the patient's care (see also paragraph 55).
- Supplementary prescribing must be supported by a regular clinical review of the patient's progress by the assessing clinician (the independent prescriber), at pre-determined intervals appropriate to the patient's condition and the medicines to be prescribed. The intervals should normally be no longer than one year (and much less than this if antibiotics are to be included in the CMP). However as stated in paragraph 17 above, longer periods, during which the patient continues to be reviewed by the supplementary prescriber, may be appropriate when the patient's condition is stable and is expected to continue to be stable.
- The independent prescriber may, *at any time*, review the patient's treatment and/or resume full responsibility for the patient's care.
- The independent prescriber and the supplementary prescriber must share access to, consult, keep up to date and use the same common patient record to ensure patient safety.

20. The key to safe and effective supplementary prescribing is the relationship between the individual independent prescriber and the individual supplementary prescriber. These two professionals should:

- Be able to communicate easily.

- Share access to, consult, keep up-to-date and use the same common patient record.
- Share access to the same local or national guidelines or protocols, where these are referred to in the CMP.
- Agree and share a common understanding of and access to the written CMP.
- Ideally, jointly review the patient's progress at agreed intervals.

### *Responsibilities*

21. The independent prescriber is responsible for:

- The initial clinical assessment of the patient, the formulation of the diagnosis and determining the scope of the CMP, which should be agreed with the supplementary prescriber.
- Reaching an agreement with the supplementary prescriber about the limits of their responsibility for prescribing and review – which should be set out in the CMP.
- Providing advice and support to the supplementary prescriber as requested.
- Carrying out a review of the patient's progress at appropriate intervals, depending on the nature and stability of a patient's condition, preferably with the supplementary prescriber being present.
- Sharing the patient's record with the supplementary prescriber.
- Reporting adverse incidents within local risk management or clinical governance frameworks, and informing the National Patient Safety Agency (NPSA) via the National Reporting and Learning System (NRLS) (this is separate from Adverse Reaction Reporting – see paragraph 75 to 76).

22. The supplementary prescriber is responsible for:

- Prescribing for the patient in accordance with the CMP. Altering the medicines and/or dosages prescribed, within the limits set out in the CMP, if monitoring of the patient's progress indicates that this is clinically appropriate.
- Monitoring and assessing the patient's progress as appropriate to the patient's condition and the medicines prescribed and responding accordingly.
- Working at all times within their clinical competence and their professional Code of Conduct, and consulting the independent prescriber as necessary.



- Accepting professional accountability and clinical responsibility for their prescribing practice.
- Passing prescribing responsibility back to the independent prescriber, if the agreed clinical reviews are not carried out within the specified interval (see paragraphs 17 and 19 above) or if they feel that the patient's condition no longer falls within their competence.
- Having input into the development of the CMP.
- Reporting adverse events which are clinically significant and keeping the independent prescriber informed of them.
- Alerting the independent prescriber of any clinically significant events.
- Recognising when they are not competent to act and passing the prescribing responsibility back to the independent prescriber.
- Recording prescribing and monitoring activity contemporaneously in the shared patient record or as soon as possible - ideally within 24 to 48 hours.

In the case of nurse supplementary prescribers, it is essential that they are clear at all times which prescribing regime they are operating under (i.e. as a DN/HV prescriber, an Extended Formulary Nurse Prescriber or as a Supplementary Prescriber).

### *Working together*

23. Independent and supplementary prescribers must be willing and able to work together and to assume the specific responsibilities listed above.
24. Independent and supplementary prescribers may work in more than one prescribing partnership, providing that in each case they work as described above.

### *The process*

25. Before starting to undertake supplementary prescribing, the supplementary prescriber will need to:
  - Successfully complete the specified training and preparation for supplementary prescribing, including all assessments and the period of learning in practice
  - Ensure that their supplementary prescribing qualification is recorded on the relevant professional register (Nursing and Midwifery Council, Royal Pharmaceutical Society of Great Britain or Health Professions Council)

- Agree with the independent prescriber to enter into a prescribing partnership with them, and record that agreement in the patient's record. Please note that the signature of either the independent prescriber or supplementary prescriber is not required.
- Agree the CMP for a patient with the independent prescriber
- Make arrangements with their employer and /or the independent prescriber for access to prescription pads or other mechanisms for prescribing which are appropriate to the setting, for example patients' drug charts in hospitals
- Arrange for access to an identified budget to meet the costs of their prescriptions
- Reach agreement with their employer that supplementary prescribing should form part of their professional responsibilities and change their job descriptions if necessary to reflect this.
- Agree any funding requirements that may be required once the supplementary prescriber has qualified and is able to prescribe.

*Conditions and health needs that can be included*

26. There are no legal restrictions on the clinical conditions that may be dealt with by a supplementary prescriber. Supplementary prescribing is primarily intended for use in managing specific long-term medical conditions or health needs affecting the patient. However, acute episodes occurring within long-term conditions may be included in these arrangements, provided they are included in the CMP.

*Patient's agreement*

27. Wherever it is proposed to manage a patient's condition through the use of supplementary prescribing, the principle underlying the concept of supplementary prescribing (i.e. a prescribing partnership) **must** be explained in advance to the patient by the independent or supplementary prescriber and their agreement should be obtained. The patient should be able to agree to being treated by a supplementary prescriber under a clinical management plan before supplementary prescribing (by a nurse, pharmacist or AHP) begins. Guidance from professional bodies will also be relevant.
28. The agreement of the patient to the prescribing partnership should be recorded in the CMP and patient record. Without such agreement, supplementary prescribing may not

proceed. Note that it is not necessary for the patient to sign the CMP, but an indication of agreement needs to be recorded.

### **Who can undertake supplementary prescribing?**

*Which nurses, pharmacists, chiropodists/podiatrists, physiotherapists and radiographers can be supplementary prescribers?*

29. A nurse supplementary prescriber must be a 1<sup>st</sup> level Registered Nurse or Registered Midwife whose name in each case is held on the NMC professional register, with an annotation signifying that the nurse has successfully completed an approved programme of preparation and training for supplementary prescribing.
30. A supplementary prescriber who is a pharmacist must be a registered pharmacist whose name is held on the membership register of the Royal Pharmaceutical Society of Great Britain, with an annotation signifying that the pharmacist has successfully completed an approved programme of training for supplementary prescribing.
31. A supplementary prescriber who is a chiropodist/podiatrist, physiotherapist or radiographer must be a registered professional whose name is held on the relevant part of the Health Professions Council membership register with an annotation signifying that the individual registrant has successfully completed an approved programme of training for supplementary prescribing.

*Selection of nurses, pharmacists, chiropodists/podiatrists, physiotherapists and radiographers to be trained*

32. The selection of nurses, pharmacists, *chiropodists/podiatrists, physiotherapists and radiographers* who will receive training in prescribing is a matter for local decision, in the light of potential benefits for patients and local NHS needs. All individuals selected for prescribing training must have the opportunity to prescribe in the post they will occupy on completion of training.
33. In addition to fulfilling the legal criteria for eligibility to prescribe, applicants who are selected for prescribing preparation will need to meet the following:

- Nurses should have the ability to study at Level 3 (degree level), pharmacists the ability to study at a **minimum** of QAA level 3 and AHPs the ability to study at a **minimum** of level 3.
- Nurses should normally have at least three years post-registration clinical nursing experience and pharmacists should have at least 2 years experience as a pharmacist, following their pre-registration year after their graduation. AHPs should normally have at least 3 years relevant post-qualification experience.
- The support of their employer to confirm that:
  - their post is one in which they will have the need and opportunity to act as a supplementary prescriber;
  - for nurses , pharmacists and AHPs in primary care, they will have access to a budget to meet the costs of their prescriptions on completion of the course;
  - they will have access to continuing professional development (CPD) opportunities on completion of the course;
  - local NHS need – PCTs and NHS Trusts will decide whether there is a local NHS need for staff to undertake supplementary prescribing training. Professionals should not be able to undertake training unless there has been prior agreement about the therapeutic area in which the professional will prescribe.

34. There are likely to be many nurses, pharmacists and AHPs in any local health economy who meet these criteria. The three key principles that should be used to prioritise potential applicants are:

- patient safety;
- maximum benefit to patients and the NHS in terms of quicker and more efficient access to medicines for patients;
- improved quality of care;
- better use of these professionals' skills.

## **Training and preparation for supplementary prescribing**

35. Nurses training to become supplementary prescribers will undertake a specific programme of preparation at degree level (level three). This programme comprises at least 26 taught days at a Higher Education Institution plus 12 days 'learning in practice', during which a designated supervising medical practitioner will provide the student with supervision, support and opportunities to develop competence in prescribing practice. The programme of training and preparation may be spread over a period of 3 to 6 months. Such nurses will also qualify to prescribe independently from the Nurse Prescribers' Extended Formulary. The nurse will also need to undertake an element of self-directed learning. Those nurses who have already qualified to prescribe from the Nurse Prescribers' Extended Formulary will only need to undertake an additional one to two days preparation on supplementary prescribing.
36. Pharmacists training to be supplementary prescribers will undertake a specific programme of training at least at QAA level three (i.e. degree level). This programme will comprise around 25 taught days (which could be a combination of desk-based learning, open learning or distance learning. However, it is important that there is some desk-based learning where there is the opportunity to learn from and support peers) at a Higher Education Institution, which could be a school of pharmacy, plus at least 12 days 'learning in practice' (see paragraph 35 above re "learning in practice").
37. Some universities already offer nurses and pharmacists the opportunity to undertake part of their course through distance learning. This facility will also be open to AHPs.
38. AHPs training to be supplementary prescribers will undertake a specific programme of training at least at degree level. This programme will comprise at least 26 taught days provided by a Higher Education Institution (normally over a period of three to six months and no longer than a period of 12 months). Plus at least 12 days "learning in practice" (see paragraph 35 above re "learning in practice").
39. It will be for PCTs and NHS Trusts with SHA Workforce Development Directorates (WDDs)/Workforce Development Confederations (WDCs) to determine which nurses, pharmacists, chiropodists/podiatrists, physiotherapists and radiographers are put forward for the programme of training and preparation. Close collaboration between the Trust

and WDDs/WDCs is crucially important to ensure that the right candidates are sent on supplementary prescribing training courses.

40. In November 2002, the Nursing and Midwifery Council (NMC) agreed a set of standards for the preparation of nurse, midwife and health visitor prescribers. A web link to these is attached at annex A. The NMC is responsible for quality assuring the specific programmes that Higher Education Institutions put forward for approval. Although some Universities and pharmaceutical companies already offer training and education in aspects of pharmacology and medicines management, only NMC approved programmes of preparation for nurse prescribing will be accepted by them when recording a nurse's qualification. Higher Education Institutions offering the specific programme of preparation may accredit the nurse's prior learning. In addition, the National Prescribing Centre has published "Maintaining Competency in Prescribing: An outline framework to help nurse supplementary prescribers". A web link to this document is attached in annex B.
  
41. In October 2002, the Royal Pharmaceutical Society of Great Britain endorsed a curriculum for pharmacists to become supplementary prescribers. A web link to the outline curriculum for training in prescribing for pharmacists is attached at annex A. The RPSGB is responsible for accrediting courses provided by Higher Education Institutions. Pharmacists will normally be expected to complete the full training programme. However, HEIs offering an agreed programme of training may accredit the pharmacist's prior learning in prescribing. All candidates must complete all assessments, including satisfactory completion of the period of learning in practice. In addition, the National Prescribing Centre has published "Maintaining Competency in Prescribing: An outline framework to help pharmacist supplementary prescribers". A web link to this document is attached at annex B.
  
42. The Department of Health led a multi-disciplinary group which produced an outline curriculum for chiropodists, physiotherapists and radiographers to train as supplementary prescribers. This curriculum was considered and agreed by the Health Professions Council. A web link to the outline curriculum for training in prescribing for these professions is attached at annex A to these guidelines. The HPC will be responsible for accrediting courses provided by Higher Education Institutions. Chiropodists/podiatrists, physiotherapists and radiographers will normally be expected to

complete the full training programme. However, HEIs offering an agreed programme of training may accredit the professional's prior learning in prescribing. All candidates must complete all assessments, including satisfactory completion of the period of learning in practice. In addition, the National Prescribing Centre has published "Maintaining Competency in Prescribing: An outline framework to help allied health professional supplementary prescribers". A web link to this document is attached in annex B.

43. In addition to the time spent on the formal programme, it is important that employers of nurses, pharmacists and AHPs undertaking the programme should recognise the demands of private study and provide support where necessary. It would be helpful if employers could provide mentoring.
44. The programme for nurses and midwives includes an assessment of theory and practice that must be passed by nurses, before the student's entry on the NMC register can be annotated to indicate that they hold the prescribing qualification for Extended Formulary nurse prescribing and supplementary prescribing.
45. Pharmacists and Allied Health Professionals will be required to pass all components of the assessment, prior to the Royal Pharmaceutical Society of Great Britain's / Health Professions Council's register being annotated to indicate that they have successfully completed the programme and have qualified as supplementary prescribers.
46. Central funding is being made available through SHA Workforce Development Directorates (WDDs) to meet the costs of training. It is for WDDs to decide how this funding is best used provided the required number of professionals are trained. WDDs may wish to draw up criteria for access to funds for training based on local NHS need; they may also wish to draw up a list of criteria for access to funds over and above those for training. NHS employers may also of course utilise their own training funds for this purpose. (See paragraphs 29 – 34 for further details).

47. It is highly desirable that independent prescribers who wish to take part in a supplementary prescribing partnership first undertake a short period of training which outlines the requirements of supplementary prescribing; their responsibilities in the partnership and delivery of training including the requirements of the “learning in practice” element of the training. This may not necessarily require attendance at a Higher Education Institution but they may offer this opportunity: learning materials may be made available for use in the workplace, or PCTs/WDDs may wish to set up local events.

#### *Continuing Professional Development (CPD)*

48. All nurses, pharmacists and AHPs have a professional responsibility to keep themselves abreast of clinical and professional developments. Supplementary prescribers will be expected to keep up-to-date with best practice in the management of conditions for which they may prescribe, and in the use of the medicines, dressings and appliances. Nurses may use the learning from this activity as part of their Post Registration Education and Practice (PREP-CPD) activity. For pharmacists it will contribute to the RPSGB’s CPD requirements which will become statutory in 2005 with regular reviews of the pharmacist’s CPD records by the RPSGB. The curriculum for pharmacists states that pharmacists who register as supplementary prescribers will need to demonstrate evidence of relevant CPD to ensure that their prescribing skills are kept up-to-date and are extended as their prescribing role develops. From 2005, AHP registrants will also have to meet the requirements of the Standards for Continuing Professional Development of the HPC. This will be a self-declaration that they have kept up-to-date with practice within their current context and scope of practice. It will be subject to periodic audit, requiring the registrant to submit evidence of their CPD to the HPC for scrutiny to support their claim. The employer should ensure that the practitioner has access to relevant education and training provision. The Department of Health has commissioned CPD support for supplementary prescribers through the National Prescribing Centre (see [www.npc.co.uk](http://www.npc.co.uk)). The Centre for Pharmacy Post-Graduate Education also offers programmes that may be relevant for pharmacist supplementary prescribers (see CPPE website [www.cppe.man.ac.uk](http://www.cppe.man.ac.uk))



## **Evaluation Audit and Clinical Governance of Supplementary Prescribing**

49. Supplementary prescribing needs to take place within a comprehensive framework of clinical governance that covers all staff.
50. Nurses should use clinical supervision arrangements as an opportunity for reflection on prescribing, as well as other aspects of practice. The model of clinical supervision should be agreed at local level, taking account of other staff support mechanisms and resources.
51. Peer review, support and mentoring arrangements should be established for pharmacists. Audits and clinical governance arrangements will allow pharmacists to reflect on their prescribing practice. The RPSGB has developed a clinical governance framework both for pharmacist supplementary prescribers and the organisations within which they work, which can be reflected in the employer organisation's overall clinical governance framework. The framework also details the supplementary prescriber's responsibility to engage in clinical governance activities. The framework is available at [www.rpsgb.org.uk](http://www.rpsgb.org.uk)
52. A review of supplementary prescribing should be carried out as part of the overall prescribing monitoring arrangements and as a suitable area of practice for regular audit. This should include prescription and cost data available from the Prescription Pricing Authority.
53. The supplementary prescriber together with his or her employer must put in place specific actions to regularly evaluate the safety, effectiveness, appropriateness and acceptability of their prescribing.
54. Other assistance with identifying audit methodologies and interpreting findings should be available through the employing organisations' normal clinical governance mechanisms. The employing organisation should ensure that supplementary prescribing is included within their overall clinical governance framework.

## **The Clinical Management Plan (CMP)**

55. The Clinical Management Plan (CMP) is the corner stone of supplementary prescribing. Before supplementary prescribing can take place, it is *obligatory* for an agreed CMP to be in place (written or electronic) relating to a named patient and to that patient's specific condition(s) to be managed by the supplementary prescriber. This should be included in the patient record. Regulations specify that the CMP must include the following:

- The name of the patient to whom the plan relates.
- The illness or conditions which may be treated by the supplementary prescriber.
- The date on which the plan is to take effect, and when it is to be reviewed by the doctor or dentist who is party to the plan.
- Reference to the class or description of medicines or types of appliances which may be prescribed or administered under the plan.
- Any restrictions or limitations of strength or dose of any medicine which may be prescribed or administered under the plan, and any period of administration or use of any medicine or appliance which may be prescribed or administered under the plan.

**[NB The CMP may include a reference to published national or local guidelines. However these must clearly identify the range of the relevant medicinal products to be used in the treatment of the patient, and the CMP should draw attention to the relevant part of the guideline. The guidelines also need to be easily accessible]**

- Relevant warnings about known sensitivities of the patient to, or known difficulties that the patient may have with particular medicines or appliances.
- The arrangements for notification of:-
  - a) Suspected or known reactions of clinical significance to any medicine which may be prescribed or administered under the plan, and suspected or known clinically significant adverse reactions to any other medicine taken at the same time as any medicine prescribed or administered under the plan, and
  - b) Incidents occurring with the appliance which might lead, might have led or has led to the death or serious deterioration of state of health of the patient

**[See paragraphs 75-76 about Adverse Reaction Reporting]**

- The circumstances in which the supplementary prescriber should refer to, or seek the advice of, the doctor or dentist who is party to the plan.

56. The CMP should be kept as simple as possible. It may refer to national or local evidence-based guidelines to identify the medicines that are to be prescribed, or

circumstances in which dosage, frequency or formulation should be changed. There is no need to repeat the advice in these guidelines in the body of the CMP itself, nor need the CMP repeat detailed patient information that is contained in the patient's record shared by both prescribers, unless such information is essential for clarity and patient safety.

57. Following diagnosis by the independent prescriber, the independent and supplementary prescriber will generally need to discuss the detail of the CMP before the document itself is prepared. Either the independent or supplementary prescriber may draft the CMP; however, both must formally agree to the CMP before supplementary prescribing can begin. This does not mean that both parties have to sign the CMP. There should be a note on the patient record that both parties have agreed to the CMP.
  
58. The independent prescriber and supplementary prescriber must share access to, consult and use the same part of the common patient record. Shared electronic records are ideal, but existing paper records or patient-held records can also be used. The CMP may need to contain different levels of detail, if the independent and supplementary prescriber work in different locations (e.g. a hospital-based independent prescriber and an outreach supplementary prescriber in the patient's home). Potential templates for CMPs can be found at Annexes C and D to this document, and have been posted on the Department of Health website [www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/SupplementaryPrescribing/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/SupplementaryPrescribing/fs/en) see also paragraph 16. However, these are not mandatory but are provided as templates if people wish to use, or adapt them.
  
59. It is for the independent prescriber to determine the extent of the responsibility he or she wishes to give to the supplementary prescriber under the CMP. The independent prescriber will clearly need to take account of the experience and areas of expertise of the supplementary prescriber, and the professional relationship between the independent and supplementary prescriber(s), when coming to this decision.
  
60. The CMP comes to an end :-
  - at any time at the discretion of the independent prescriber or the supplementary prescriber;
  - at the request of the supplementary prescriber or the patient

- at the time specified for the review of the patient (unless it is renewed by both prescribers at that time);
- where there is a sole independent prescriber and he or she is replaced for whatever reason. In these circumstances the CMP must be reviewed by their successor;
- if a CMP is in place and the locum is happy then he should sign it and then the supplementary prescriber can continue to prescribe.

### **Medicines prescribable under supplementary prescribing arrangements**

61. Where a nurse or pharmacist is the supplementary prescriber, a CMP may include any General Sales List, Pharmacy, or Prescription Only Medicine prescribable at NHS expense, This includes the prescribing of:
- Antimicrobials
  - “Black triangle” drugs and those products suggested by the British National Formulary to be “less suitable” for prescribing
  - Controlled Drugs (except those listed in Schedule 1 of ‘The Misuse of Drugs Regulations 2001’ that are not intended for medicinal use).
  - Products used outside their UK licensed indications (i.e. “off-label” use). Such use must have the joint agreement of both prescribers and the status of the drug should be recorded in the CMP.
  - Unlicensed drugs (that is, a product that is not licensed in the UK).
62. Where an AHP is the supplementary prescriber, a CMP may include any General Sales List, Pharmacy, or Prescription Only Medicine prescribable at NHS expense, with the current exception of Controlled Drugs. This includes the prescribing of:
- Antimicrobials
  - “Black triangle” drugs and those products suggested by the British National Formulary to be “less suitable” for prescribing
  - Products used outside their UK licensed indications (i.e. “off-label” use). Such use must have the joint agreement of both prescribers and the status of the drug should be recorded in the CMP.
  - Unlicensed drugs (that is, a product that is not licensed in the UK).

63. The independent prescriber will need to be aware of the high risk nature of many drugs prescribed under local shared care guidelines (e.g. Methotrexate) and the specific monitoring requirements to support the safe and efficacious use of these drugs. Before undertaking a supplementary prescribing arrangement involving any high risk drug, the independent prescriber will need to assure him/herself that the supplementary prescriber has the level of skill/knowledge and is competent to take part in such an arrangement.
- 64. A supplementary prescriber should not agree to prescribe any medicine if s/he feels that his/her knowledge of the medicines falls outside his/her area of competence.**

### **The Patient Review**

65. The patient review must take place after the interval stated in the CMP. This may be a joint review by both prescribers seeing the patient together. Where this is not possible, the independent prescriber should review the patient, and subsequently discuss future management of the patient's condition(s) with the supplementary prescriber. Both prescribers must record their agreement to the continuing or amended CMP, and the patient's agreement to the continuation of the supplementary prescribing arrangement, in order for the CMP to remain valid. They should then set a new date for review. Prescribing by the supplementary prescriber after the date of review, and without recorded agreement to the next phase of the CMP, should not continue.

### **Good practice, ethics and issues common to all supplementary prescribers**

#### *Stock items*

66. In primary care settings, prescriptions should not be written when an item has been administered to a patient using GP surgery or clinic stock items, because the cost of these items is already covered through the indirect reimbursement of practice expenses/Primary Care Trust service level agreements respectively. The exception is in circumstances where the medical practitioner is eligible for direct reimbursement. These items are listed in paragraph 17.4 of the 'GMS Statement of Financial Entitlements'. When prescribing any of these items for personal administration, the prescriber should endorse "PA" on the front of the prescription form. Claims for specified high volume

personally administered vaccines must be made as bulk entries on the relevant version of the prescription invoice form FP34 and FP34 (Appendix), following current instructions.

### *Informing patients*

67. Supplementary prescribers must ensure that patients are aware of the scope and limits of supplementary prescribing and how the patient or client can obtain other items necessary for their care.

### *Prescribing for self, family and friends*

68. Other than in emergencies, any prescriber must not prescribe any drug for themselves or anyone with whom they have a close personal or emotional relationship.

### **Patient Records**

69. All health professionals are required to keep accurate, legible, unambiguous and contemporaneous records of a patient's care. There is no single model or template for a patient record (although for guidance staff should refer to the standards published by the relevant professional/regulatory body), but a good record is one that provides all professionals involved in a patient's treatment, with the information necessary for them to care safely and effectively for that patient. It is an invaluable way of promoting communication within the healthcare team and between practitioners and their patients/clients. Good record keeping is, therefore, both the product of effective team working and a tool in promoting high quality health care. Arrangements for the sharing of patient records should be put into place at the same time as the supplementary prescribing partnership is set up.
70. Best practice suggests that the details of any prescription, together with other details of the consultation with the patient, should be entered onto the shared patient record immediately, or as soon as possible after the consultation. **Only in exceptional circumstances (e.g. the intervention of a weekend or public holiday) should this period exceed 48 hours from the time of writing the prescription.** This information should also be entered at the same time onto the nursing patient record (where a separate nursing record exists).

71. It is recommended that the record indicate clearly:

- The date of the prescription;
- The name of the prescriber (together with the fact that they are acting as a supplementary prescriber);
- The name of the item prescribed, together with the quantity (or dose, frequency and treatment duration).

72. For medicinal preparations (items to be ingested or inserted into the body), the record should include:

- The name of the item prescribed, the strength (if any) of the preparation, the dosing schedule and route of administration e.g. ‘paracetamol oral suspension 120mg/5mls to be taken every 4 hours by mouth as required for pain, maximum of 20mls in any 24 hours’.

73. In the case of topical medicinal preparations the name of the prescribed item, the strength (if any), the quantity to be applied and the frequency of application should be indicated. For dressings and appliances, details of how they are to be applied and how frequently changed, are useful. It is recommended that any advice given on GSL (also known as ‘over the counter’) items be recorded.

74. In some circumstances, it may be necessary, in the clinical judgement of the supplementary prescriber, to advise the independent prescriber immediately about the prescription. This action should be recorded in the shared patient record.

### **Adverse Reaction Reporting**

75. If a patient suffers a clinically significant suspected adverse reaction to a prescribed, over-the-counter (General Sales List) or herbal medicine, the adverse reaction should be reported via the Yellow Card Scheme. The Yellow Card Scheme is a voluntary scheme through which healthcare professionals notify the Medicines and Healthcare Products Regulatory Agency (MHRA)/Committee on the Safety of Medicines (CSM) of suspected adverse drug reactions. The MHRA/CSM encourage the reporting of all suspected adverse drug reactions to newly licensed medicines that are under intensive monitoring/surveillance (identified by a □ symbol both on the product information for

the drug and in the BNF and MIMS) and all serious suspected adverse drug reactions to all other established drugs. Serious reactions include those that are fatal, life threatening, disabling, incapacitating or which result in or prolong hospitalisation and/or are medically significant. The new electronic Yellow Card provides a simple and fast way to report suspected adverse reactions. The electronic Yellow Card, together with instructions on how to use it, is available at [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk) Health professionals are encouraged to report all suspected adverse drug reactions using this method, although hard copy Yellow Cards are also acceptable (and can be found bound to the back of the British National Formulary). The supplementary prescriber must also inform the independent prescriber of any reported ADRs.

76. The bulletin “Current Problems In Pharmacovigilance”, issued by the MHRA and the CSM, contains advice and information on drug safety issues. All supplementary prescribers are encouraged to consult the bulletin as a matter of routine. Copies are also available from the MHRA’s website, which can be found on [www.mhra.gov.uk](http://www.mhra.gov.uk)

#### *Role of the National Patient Safety Agency*

77. If a patient suffers harm due to an adverse incident involving medicines, or if harm could have been caused to the patient by the medicine (a near miss), the incident or near miss should be reported by the supplementary prescriber using both local and national reporting systems. The National Patient Safety Agency (NPSA), a special health authority, was established in 2001 to improve the safety of NHS patient care, by promoting a culture of reporting and learning from adverse incidents across the NHS. A new reporting system, the National Reporting and Learning System (NRLS), has been developed by the Agency to draw together information on adverse incidents. This will help the NHS to understand the underlying causes of patient safety problems and act to introduce practical changes to prevent mistakes.
78. All NHS organisations in England and Wales can now submit reports of patient safety incidents to the NRLS. These reports will enable the NPSA to build a clearer national picture of the problems affecting patient safety.



79. The NRLS allows NHS staff and independent contractors to report the incidents that they are involved in or witness, confidentially and anonymously. Two routes are available to enable them to report:

- A direct reporting route to the NPSA using the electronic reporting form – known as the eForm – available on the NPSA website at [www.npsa.nhs.uk/staffform/](http://www.npsa.nhs.uk/staffform/) .
- Reporting through the local healthcare organisation's established system.

80. For community pharmacists who are supplementary prescribers, confidential reporting of patient safety incidents to the NRLS is one of the terms of the new community pharmacy contract. A third reporting route is available for pharmacists through the existing risk management systems that large community pharmacy organisations already have in place. These company systems will be integrated with the NRLS.

81. The NPSA will publish statistics on trends and issues identified through the NRLS to promote a learning culture in the NHS. The Agency will also use the data to deliver effective, practical and timely solutions to the NHS to help staff and organisations improve the safety of the patients they care for. Further information on the NPSA can be found on the Agency's website [www.npsa.nhs.uk](http://www.npsa.nhs.uk) .

## **Legal and Clinical Liability**

### *Liability of employer*

82. Where a nurse, midwife, pharmacist, chiropodist/podiatrist, physiotherapist or radiographer is appropriately trained and qualified and prescribes as part of their professional duties with the consent of their employer, the employer is held vicariously liable for their actions. In addition, nurse supplementary prescribers are individually professionally accountable to the Nursing and Midwifery Council (NMC) for this aspect of their practice, as for any other, and must act at all times in accordance with the NMC Code of Professional Conduct. Pharmacist supplementary prescribers are individually accountable to the RPSGB and must at all times act in accordance with the RPSGB Code of Ethics and Standards. AHP supplementary prescribers are individually professionally accountable to the Health Professions Council (HPC) and must at all times act in accordance with the HPC's Standards of conduct, performance and ethics.

### *Professional indemnity*

83. All supplementary prescribers should ensure that they have professional indemnity insurance, for instance by means of membership of a professional organisation or trade union. (The RPSGB Code of Ethics states that all pharmacists who own a pharmacy, superintendent pharmacists and pharmacist managers should ensure that all professional activities undertaken by them or under their control are covered by adequate professional indemnity insurance.)

### **Dispensing of prescribed items**

#### *Dispensing Doctors in primary care*

84. Where a GP practice is a dispensing practice, prescriptions from supplementary prescribers can be dispensed by the practice but only for the dispensing patients of that practice. Dispensing Doctors cannot dispense prescriptions written by supplementary prescribers for patients of other practices.
85. When submitting prescription forms prior to sending them to the PPA, dispensing practices should follow the sorting instructions on the prescription invoice.
86. Reimbursement for prescriptions written by supplementary prescribers can be claimed by Dispensing Doctors; payment for the prescriptions submitted will be made to the senior partner.

### *Role of the pharmacist in dispensing pharmacist supplementary prescribers' prescriptions*

87. The DH would normally expect separation of prescribing and dispensing roles in keeping with the principles of safety, and clinical and corporate governance. However, in exceptional circumstances and in the context of supplementary prescribing, dispensing and prescribing can co-exist, provided clear accountability arrangements are in place to assure patient safety and probity and there are audit and clinical governance arrangements in place which can track prescribing and dispensing by a supplementary prescriber. Where the two roles do co-exist, a final accuracy check must be carried out by another person, ideally a qualified pharmacy technician.
88. The rules for dispensing and reimbursement of supplementary prescribers' prescriptions are the same as for GP prescriptions.
89. When sorting prescription forms prior to sending them to the PPA, community pharmacies should follow the sorting instructions on the prescription invoice – Form FP34C.

### **Verification of prescribing status**

#### *Role of the pharmacist on verification of prescribing status*

90. The dispensing pharmacist will need to be sure that the prescriber has qualified as either an independent nurse prescriber or a supplementary prescriber (see also paragraphs 96-101 below). In the case of District Nurse/Health Visitor prescribers, the pharmacist will also need to check that the drugs or appliances prescribed are included in the Nurse Prescribers' Formulary for District Nurses and Health Visitors. It will not be possible for a dispensing pharmacist to check whether a nurse is prescribing as an Extended Formulary Nurse Prescriber or as a Nurse Supplementary Prescriber, as the nurse will more often than not be qualified as both and there is no formulary for supplementary prescribers. The dispensing pharmacist will, of course, continue to need to use their professional judgement, as they do for doctors' prescriptions, to assess whether a prescription is clinically appropriate for a particular patient.

91. Dispensing pharmacists should ensure that they know the local procedure for resolving any queries with the supplementary prescriber or their independent prescriber partner. Dispensing pharmacists are NOT required to check that the supplementary prescriber is acting within the parameters of the CMP, that is the responsibility of the organisation that the supplementary prescriber is working within. For pharmacies that do not have access to the internet it may be possible to verify the prescribing status of the pharmacist by calling the RPSGB on 020 7572 2322.
92. To enable pharmacists to check whether a prescription handed in for dispensing is bona fide, all NHS employers should keep a list of all supplementary prescribers employed by them. It is also recommended that the employing authority holds a copy of the prescriber's signature. Individuals should be prepared to provide specimen signatures to pharmacists, should that be required.

*The NMC Voice Bank*

93. Most enquiries from dispensing pharmacists will be resolved by telephoning the prescriber, the prescriber's employer or the PCT. However, for general queries about qualification (e.g. in the case of receiving a private prescription), the pharmacist can telephone the 24-hour NMC voice bank system<sup>1</sup>. Pharmacists should clearly state that they are checking the prescribing status of an individual. They should then be asked to give the nurse prescriber's NMC number and name. If the pharmacist fails to state that he/she is checking prescribing status, the NMC operator will assume the pharmacist is the nurse's employer and will ask a number of further questions to which the pharmacist will not have the answer.

*Pharmacist supplementary prescribers*

94. The RPSGB has an on-line web access [www.rpsgb.org.uk/society](http://www.rpsgb.org.uk/society), which provides a list of pharmacists registered either by name or registration number. This enables 24-hour access and will incorporate an indicator of prescribing status.

### *Allied Health Profession supplementary prescribers*

95. The Health Professions Council has its own on-line web access at [www.hpc-uk.org/register](http://www.hpc-uk.org/register). They can also be contacted on 0845 300 4472 or the register can be purchased in CD-ROM format from the HPC offices.

### *Role of the PPA*

96. The PPA will only check to ensure that prescriptions written by a District Nurse/Health Visitor prescriber are restricted to items included in the DN/HV Formulary. For the reasons set out in paragraph 90 above, it will not be possible for the PPA to check whether a nurse is prescribing as an Extended Formulary or Supplementary Prescriber – or to check the validity of prescriptions written by other Supplementary Prescribers.

### **Dispensing by appliance contractors**

97. When a supplementary prescriber becomes aware that the patient intends to have a prescription dispensed by an appliance contractor, they must ensure that the prescription does not contain medicinal preparations (Appliance contractors cannot dispense medicinal preparations). When sorting prescription forms prior to sending them to the PPA, appliance contractors should follow the sorting instructions on the prescription invoice – Form FP34A.

### **Urgent dispensing**

98. Occasionally prescriptions may require dispensing out of normal pharmacy opening hours. The prescription form should be endorsed by the prescriber with the word “Urgent”. A pharmacist may claim an additional fee for dispensing a prescription urgently. Arrangements for dispensing out of normal hours vary, but details may be available at PCTs, local pharmacies, NHS Direct or police stations.

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<sup>1</sup> Telephone number 020 7631 3200

## **Dispensing of items in Wales, Scotland and Northern Ireland**

99. Prescriptions written by supplementary prescribers in England will only be dispensable by pharmacists in Wales, Scotland and Northern Ireland when the devolved administrations amend their pharmaceutical regulations, to permit them to be dispensed at NHS expense.

## **Dispensing items against a nurse/pharmacist/AHP/optometrist prescription in hospital pharmacies**

100. An up-to-date list of all qualified supplementary prescribers employed by the hospital will need to be kept in the hospital pharmacy. Pharmacy staff should check the prescriber status against the list. The same process will apply for in-patient, outpatient and discharge prescriptions.

## **Budget Setting and Monitoring**

101. The Department of Health issues detailed guidance to inform all those involved in allocating resources and local budget setting. Guidance is available on three websites:

- PCT ([www.dh.gov.uk/pricare/pcts.htm](http://www.dh.gov.uk/pricare/pcts.htm));
- Finance Manual ([www.dh.gov.uk/finman.htm](http://www.dh.gov.uk/finman.htm)); and
- Prescribing Support Unit (PSU) ([www.psu.ppa.nhs.uk](http://www.psu.ppa.nhs.uk)).

### *Supplementary prescribing monitoring information*

102. The PPA reimburses costs to dispensing contractors and provides essential information, both electronically and via paper reports, to authorised users. Prescribing by nurse supplementary prescribers will be included in Extended Formulary nurse prescribing data. Prescribing by pharmacist supplementary prescribers will be identifiable in ePACT.net services and other PPA Information Systems where appropriate. Prescribing by AHP supplementary prescribers will be identifiable in national data available from the PPA. Supplementary Prescribers can expect to receive information via their PCT, GP Practice, Walk-in Centres and Out of Hour Care Providers which will help to monitor their prescribing. Individual supplementary prescriber PACT Catalogues

(giving details down to individual presentation and prescription quantity level) are only available on request.

Requests from the supplementary prescriber's employer should be made on headed notepaper to:-

PPA

Prescriber Information

Prescription Pricing Authority

Scottish Life House

Archbold Terrace

Jesmond

Newcastle upon Tyne

NE2 1DB

103. Hospital employers may find it beneficial to collect and analyse prescribing data on supplementary prescribers alongside the routine monitoring of prescribing by doctors.

## **Annex A – Outline curriculums for training supplementary prescribers**

### **Nurses**

The NMC's requirements for Extended Independent nurse prescribing and supplementary prescribing

[www.nmc-uk.org/nmc/main/employers/nmcCircular2502.pdf](http://www.nmc-uk.org/nmc/main/employers/nmcCircular2502.pdf)

### **Pharmacists**

Royal Pharmaceutical Society of Great Britain – Outline Curriculum for Training Programmes to prepare Pharmacist Supplementary Prescribers

[www.rpsgb.org/pdfs/suplprescphoutlcurric.pdf](http://www.rpsgb.org/pdfs/suplprescphoutlcurric.pdf)

### **Allied Health Professionals**

Preview Edition of Outline Curriculum

[www.dh.gov.uk/assetRoot/04/08/90/03/04089003.pdf](http://www.dh.gov.uk/assetRoot/04/08/90/03/04089003.pdf)



## **Annex B – Maintaining competency in prescribing - Outline frameworks**

### **Nurses**

Maintaining competency in prescribing – an outline framework to help nurse supplementary prescribers

[www.npc.co.uk/nurse\\_prescribing/pdfs/nurse\\_update\\_framework.pdf](http://www.npc.co.uk/nurse_prescribing/pdfs/nurse_update_framework.pdf)

### **Pharmacists**

Maintaining competency in prescribing – An outline framework to help pharmacist supplementary prescribers

[www.npc.co.uk/publications/maint\\_compt\\_presc/maint\\_compt\\_presc.htm](http://www.npc.co.uk/publications/maint_compt_presc/maint_compt_presc.htm)

### **Allied Health Professionals**

Maintaining competency in prescribing – an outline framework to help Allied Health Professional supplementary prescribers

[www.npc.co.uk/maintain\\_comp\\_in\\_prescribing.htm](http://www.npc.co.uk/maintain_comp_in_prescribing.htm)

ANNEX C

**TEMPLATE CMP 1 (Blank): for teams that have full co-terminus access to patient records**

Name of Patient:		Patient medication sensitivities/allergies:		
Patient identification e.g. ID number, date of birth:				
Independent Prescriber(s):		Supplementary Prescriber(s)		
Condition(s) to be treated		Aim of treatment		
<b><u>Medicines that may be prescribed by SP:</u></b>				
<b><u>Preparation</u></b>	<b><u>Indication</u></b>	<b><u>Dose schedule</u></b>	<b><u>Specific indications for referral back to the IP</u></b>	
Guidelines or protocols supporting Clinical Management Plan:				
<b><u>Frequency of review and monitoring by:</u></b>				
Supplementary prescriber		Supplementary prescriber and independent prescriber		
Process for reporting ADRs:				
Shared record to be used by IP and SP:				
<b>Agreed by independent prescriber(s)</b>	<b>Date</b>	<b>Agreed by supplementary prescriber(s)</b>	<b>Date</b>	<b>Date agreed with patient/carer</b>

**ANNEX D**

**TEMPLATE CMP 2 (Blank): for teams where the SP does not have co-terminus access to the medical record**

<b>Name of Patient:</b>		<b>Patient medication sensitivities/allergies:</b>		
<b>Patient identification e.g. ID number, date of birth:</b>				
<b>Current medication:</b>		<b>Medical history:</b>		
<b>Independent Prescriber(s):</b>		<b>Supplementary prescriber(s):</b>		
Contact details: [tel/email/address]		Contact details: [tel/email/address]		
<b>Condition(s) to be treated:</b>		<b>Aim of treatment:</b>		
<b>Medicines that may be prescribed by SP:</b>				
<u>Preparation</u>	<u>Indication</u>	<u>Dose schedule</u>	<u>Specific indications for referral back to the IP</u>	
<b>Guidelines or protocols supporting Clinical Management Plan:</b>				
<b>Frequency of review and monitoring by:</b>				
<b>Supplementary prescriber</b>		<b>Supplementary prescriber and independent prescriber</b>		
<b>Process for reporting ADRs:</b>				
<b>Shared record to be used by IP and SP:</b>				
.				
<b>Agreed by independent prescriber(s):</b>	<b>Date</b>	<b>Agreed by supplementary prescriber(s):</b>	<b>Date</b>	<b>Date agreed with patient/carer</b>

## ANNEX E

### NOTIFICATION OF PRESCRIBER DETAILS TO PPA

1. The details of supplementary prescribers employed by a Community NHS Trust, PCT, GMS/PMS/APMS contractor, Walk in Centre or Out of Hours Care provider must be registered with the PPA before prescriptions for that prescriber can be ordered.
2. Notification of required details by the prescribers' employer to the Prescription Pricing Authority (PPA) enables the setting up of automatic monitoring processes as well as allowing the provision of prescriber details to the supplier (currently Astron) for the printing of prescription pads.
3. Employers of all supplementary prescribers practising in primary care are therefore required<sup>2</sup> to inform the PPA of the supplementary prescriber's details using one of the following revised PPA Annex forms:
  - PPA Annex A1 – For use by Community NHS Trusts in respect of nurse and supplementary prescribers they employ;
  - PPA Annex A2 – For use by PCTs in respect of nurse and supplementary prescribers employed by a GMS/PMS/APMS contractor, Walk in Centre or Out of Hours Care provider and for community pharmacist supplementary prescribers;
  - PPA Annex A3 – For use by PCTs in respect of nurse and supplementary prescribers directly employed by the PCT.
4. The PPA Annex forms should also be used to notify the PPA of changes in circumstances (e.g. name) as they occur. These forms are available on the PPA website at [www.ppa.nhs.uk](http://www.ppa.nhs.uk)

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<sup>2</sup> Paragraph 8 of Schedule 2 to the NHS Act 1990 provides that "an NHS trust shall furnish to the Secretary of State such reports, returns and other information, including information as to its forward planning, as, and in such form as, he may require". In this case the Secretary of State is intending to require NHS trusts to furnish information direct to the Prescription Pricing Authority, in the manner prescribed on the official proforma.

- In order to avoid transposition errors, and the subsequent problems incurred, the PPA Annex forms should be completed electronically by the relevant personnel within each Primary Care Trust and Community NHS Trust and then either:

emailed to [val.peel@ppa.nhs.uk](mailto:val.peel@ppa.nhs.uk) or

printed and sent to:

PPA, Prescriber Information,  
Scottish Life House,  
Archbold Terrace,  
Jesmond,  
Newcastle upon Tyne, NE2 1DB.

6. The detail asked for on the PPA Annex forms has been kept to a minimum to reduce work for the employer. Collecting and transmitting the information will, however, require co-operation and this should ideally be discussed at the implementation stage, if such systems are not already in place. The details asked for on the PPA Annex forms include the:
  - supplementary prescriber's "personal identification number" – provided by the NMC , RPSGB, HPC or GOC
  - supplementary prescriber's name and profession
  - organisation for which the supplementary prescriber works (where relevant)
  - organisation details

#### *Changes to prescriber details*

7. It is the responsibility of employers of supplementary prescribers who are registered with the PPA and who are working in GMS/PMS/APMS contractor organisations, PCTs, Walk-In Centres and Out of Hours Care providers, to ensure that changes to the prescribers' details are notified to PPA as soon as they occur, e.g. change of name on marriage, change of telephone number. Failure to do this will mean that prescription forms will continue to be produced with the former (incorrect) details on them.
8. GMS/PMS/APMS contractors, Walk in Centre or Out of Hours Care provider employers of supplementary prescribers in primary care, and any community pharmacists acting as supplementary prescribers, should pass details to the relevant Primary Care Trust within 48 hours (excluding weekends or Bank Holidays). The Primary Care Trust will then be responsible for passing the details to the PPA using the relevant PPA Annex form.

*Prescriber ceases employment / prescribing.*

9. The employer, or the PCT in the case of community pharmacists, should inform the PPA as soon as possible when a prescriber is no longer carrying out prescribing duties (for example, because he/she has changed employer, been suspended from the relevant register or had his/her approval as a prescriber withdrawn for some reason). They should do this by submitting the relevant PPA Annex form. This includes circumstances where the employer is contracted to provide services for other commissioning organisations, e.g. nursing services through a Community Nurse Prescribing Contract.
  
10. PCTs should annotate their lists of supplementary prescribers with the reasons for any changes, to ensure that an up-to-date record exists.

## **ANNEX F**

### **PRESCRIPTION FORMS**

1. All prescription forms require information to be entered on them (by printing or writing or combination of both). In addition to the correct dispensing of the items prescribed, this allows for prescribing information and costs to be attributed to the correct prescriber and / or organisation and to the correct prescribing budget (for further information on budget setting and monitoring see paragraphs 100-102 of this Guide).

### **PRESCRIBING IN PRIMARY CARE**

#### *Ordering prescription forms*

2. Employers should note that prescription forms are not sent out automatically. PCTs should order FP10 prescriptions from the supplier (Astron). Prescriptions should also be re-ordered from Astron as and when required.
3. Orders for new prescribers' prescription forms should not be placed earlier than 42 days prior to the date the individual is scheduled to begin prescribing for your organisation, as Astron cannot access PPA data before this point.
4. Allow at least 6 working days between notifying changes to the PPA and ordering prescriptions. This will allow time for data input and transmission of updated data files to Astron. Details on orders must match PPA data held by Astron. If you order too quickly after changing the details – the order may be rejected; any orders based on details which conflict with data held by Astron will be rejected for security reasons.
5. Prescriptions are normally sent to the address of the person who orders them (you can specify an alternative address for invoicing purposes). Checks are made to ensure that FP10 prescriptions are only supplied to bona-fide NHS organisations. Difficulties with prescription orders should be addressed, in the first instance, to Astron.

*Prescription forms FP10P pre-printed by Astron.*

6. The top of the prescribing area will be overprinted to identify the type of supplementary prescriber eg:

- EFNP/NURSE SUPPLEMENTARY PRESCRIBER, or
- PHARMACIST SUPPLEMENTARY PRESCRIBER or
- CHIROPODIST SUPPLEMENTARY PRESCRIBER
- PHYSIOTHERAPIST SUPPLEMENTARY PRESCRIBER
- RADIOGRAPHER SUPPLEMENTARY PRESCRIBER

7. The address box will be overprinted to identify:

- the supplementary prescriber,
- the organisation they are prescribing on behalf of, and
- for those supplementary prescribers who are directly employed by a PCT or prescribing through a Community Nurse Prescribing Contract, a space for the relevant practice number to be added for each patient for whom they prescribe (Astron printed prescriptions only). If the prescription is printed by a GP system, the practice code will be printed in the relevant place.

8. Information about prescription overprinting and single sheet versions of the FP10P will be available on the Department of Health web page [www.dh.gov.uk/prescriptionform](http://www.dh.gov.uk/prescriptionform) and the Prescription Pricing Authority web page at [www.ppa.org.uk](http://www.ppa.org.uk) .

9. Any prescriber who works for more than one employer or in more than one setting eg

- i) – PCT directly employed prescriber providing services to those patients in the PCT and
- ii) – the same prescriber providing services to patients external to the PCT through a contract

**must** have separate prescription pads for each organisation / or use FP10SS prescriptions printed with the correct organisation details in the prescriber details area of the prescription form.



## PRESCRIBING BY HOSPITAL BASED SUPPLEMENTARY PRESCRIBERS

10. Supplementary prescribers prescribing for hospital in-patients or outpatients may use three methods to prescribe:

- Hospital in-patient prescription form or sheet – to be used for in-patients and discharge supplies only. A prescription charge is not levied for in-patients.
- Internal hospital prescription form – to be used for out patients but only in cases where the hospital pharmacy will dispense the prescription. A prescription charge may be payable, unless the patient is exempt from prescription charges. **(NB internal hospital forms cannot be accepted for dispensing by community pharmacies).**
- FP10 type prescription forms, **where the medicine will be prescribed by a hospital prescriber and dispensed in a community pharmacy**. (Note: the Prescriber's employer should establish a local policy on the use of prescription forms in these circumstances.)

11. There is currently no requirement to notify the PPA of details of hospital based supplementary prescribers, or changes to their details.

### *Ordering prescription forms*

12. Managers of hospital based supplementary prescribers should order FP10 forms as required. **FP10** type prescriptions for a hospital based nurse/pharmacist/chiropract/podiatrist/physiotherapist/radiographer should conform to community pharmacy and PPA processing requirements and be printed with prescribing account codes approved by the PPA. Where possible, they should also identify the type of supplementary prescriber at the top of the prescribing area eg

- EFNP/NURSE SUPPLEMENTARY PRESCRIBER  
PIN ..... or
- PHARMACIST SUPPLEMENTARY PRESCRIBER  
RPSGB No ..... or

- PODIATRIST/CHIROPODIST SUPPLEMENTARY PRESCRIBER  
HPC No..... or
- PHYSIOTHERAPIST SUPPLEMENTARY PRESCRIBER  
HPC No..... or
- RADIOGRAPHER SUPPLEMENTARY PRESCRIBER  
HPC No. or

For further details of what should be stamped / printed on these forms prior to issue to the prescriber and the latest guidance on form use for hospital-based prescribers switching over to "green" FP10 forms, see DH web site [www.dh.gov.uk/prescriptionform](http://www.dh.gov.uk/prescriptionform) or the PPA website at [www.ppa.org.uk](http://www.ppa.org.uk)

## **NON-NHS EMPLOYEES**

13. A non-NHS supplementary prescriber cannot issue an FP10 type prescription, i.e. one which will be dispensed in a NHS community pharmacy, unless the organisation they work for has an arrangement / contract with an NHS provider (e.g. PCT) which allows the non-NHS organisation to use NHS community pharmacy dispensing services. The NHS provider should organise the supply of FP10 type prescription forms (and obtain the prescribing code(s) to be used) for the non-NHS organisation, if this is appropriate.

## **HOW TO COMPLETE THE PRESCRIPTION FORM**

14. Detailed advice on prescription writing is contained in the Nurse Prescribers' Formulary and the British National Formulary (BNF).
15. Details required on the front of the prescription form (to be entered by writing clearly and legibly using an indelible pen (preferably black) or, where possible, by printing using a computer prescribing system) are:
- the patient's title, forename, surname and address (including postcode) and if available the patient's NHS number.

- Age and date of birth (must be printed by computer prescribing systems; for hand written prescriptions - enter if known e.g. from patient notes - BUT it is a legal requirement to write the patient's age on the prescription when prescribing Prescription Only Medicines for a child under twelve years of age).
- for prescribing in primary care and in the community, the prescription should contain the name of the prescribed item, formulation, strength (if any) dosage and frequency, and quantity to be dispensed. The quantity prescribed should be appropriate to the patient's treatment needs, bearing in mind the need to avoid waste. Some medicines are only available in patient packs (or multiples thereof)<sup>3 4</sup> and special containers<sup>5</sup> and the quantity contained should be prescribed, provided this is clinically and economically appropriate. The quantity should be specified for solid preparations as number of dose-units (number of tablets, capsules, lozenges, patches etc), for liquid measures in millilitres (mL or ml), for topical preparations by mass (grams, g) or volume (millilitres, mL or ml). Terms such as "1 Pack" or "1 OP" should not be used. Alternatively, for preparations to be given at a fixed dose and interval, the duration(s) of treatment can be given in place of quantity to be dispensed.
- In hospitals, prescriptions for in-patients should contain the name of the prescribed item, formulation, strength (if any), dosage and frequency. Where a defined length of treatment is required this should be stated. For outpatients and discharge prescriptions, the requirements are the same as those for primary/community care, whilst recognising local policies for example on the length of treatment provided for outpatients and patients who are being discharged.
- The names of medicines should be written clearly. Nurses and pharmacists are recommended to prescribe generically, except where this would not be clinically appropriate or where there is no approved generic name – see the Nurse Prescribers' Formulary for District Nurses and Health Visitors, the Nurse Prescribers' Extended Formulary, the BNF and the Drug Tariff. Names of medicines and generic titles should not be abbreviated. Exceptions to this rule are for the prescribing of some

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<sup>3</sup> A patient pack is a manufacturer's pack approved by the Licensing Authority which has a label and leaflet and contains an amount of medicine such that the pack is capable of being given whole to a patient to meet all or part of a treatment course. For some medicines special packs containing smaller quantities will be available for starter/titration/trial purposes.

<sup>4</sup> In the BNF, pack size is indicated as in this example "Net price 60-tab pack=£2.25". Wherever no pack size is indicated, as in "Net price 20=9p, the quantity is shown for price comparison purposes only.

<sup>5</sup> A special container is a pack from which it is not practicable to dispense an exact quantity, or a pack with an integral means of application. This currently includes sterile preparations, effervescent or hygroscopic products, liquid preparations which are intended to be added to bath water, coal tar preparations, viscous preparations and all products packaged in casters, tubes, dropper bottles, aerosols, puffers, roll-on packs, sachets, sprays, shakers, squeeze packs.

dressings and appliances, and of compound or modified release medicines which have no approved non-proprietary name.

- directions, which should be in English and not abbreviated.
- where there is more than one item on a form, a line should be inserted between each item for clarity.
- unused space in the prescription area of the form should be blocked out with, for example, a diagonal line (to prevent subsequent fraudulent addition of extra items).
- prescribers' signature and date.
- on hospital prescriptions only: the supplementary prescriber's name printed or hand written in the box provided (to ensure that the dispensing pharmacist is aware who to contact if s/he has a query).

*Security and safe handling of prescription forms: good practice*

16. The security of prescription forms is the responsibility of both the employing organisation and the prescriber. It is advisable to hold only minimal stocks of the prescription forms. This reduces the number lost if there is a theft or break-in, and also helps to keep prescription forms up-to-date (they are normally revised annually).
17. The prescribers' employer should record the serial numbers of prescriptions received and subsequently issued to an individual prescriber, surgeries, clinics etc.
18. Local policy should be established on monitoring the use of prescription forms to deter the creation of fraudulent prescriptions.
19. The prescriber should also keep a record of the serial numbers of prescriptions issued to him or her. The first and last serial numbers of pads should be recorded. It is also good practice to record the number of the first remaining prescription form of an in-use pad at the end of the working day. Such steps will help to identify any prescriptions that are either lost or stolen overnight.
20. Blank prescription forms must **NOT** be pre-signed, to reduce the risk of misuse should they fall into the wrong hands. In addition, prescription forms should only be produced when needed, and never left unattended. Prescription forms should not be left on a desk but placed in a locked drawer.

21. Best practice recommends that where possible, all unused forms should be returned to stock at the end of the session or day. Prescriptions are less likely to be stolen from (locked) secure stationery cupboards than from desks, bags or cars.

*Loss of prescription forms*

22. Astron (not the PPA) should be contacted about prescriptions ordered, but not received. The Counter Fraud Services should only be notified if missing items are not found.

23. All prescribers working in primary care should report any loss or theft of prescription forms to the local counter-fraud specialist at the PCT as soon as possible after the theft/loss is confirmed. The prescriber should give details of the approximate number of scripts stolen, their identification numbers, and where and when they were stolen.

24. In consultation with regional or national counter-fraud operational teams where appropriate, the PCT/NHS local counter-fraud specialist at the trust should notify local pharmacists and decide upon any necessary action to minimise the abuse of the forms. The local counter-fraud specialist at the PCT/NHS trust should also inform the Compliance Unit at the DCFS.

25. Following the reported loss of a prescription form, the PCT will normally tell the prescriber to write and sign all prescriptions in a particular colour (usually red) for a period of 2 months. The PCT will inform all pharmacies in their area and adjacent PCTs of the name and address of the prescriber concerned; the approximate number of prescription forms stolen and the period within which the prescriber will write in a specific colour. This will normally be put in writing within 24 hours with the exception of weekends.

26. In the event of a loss or suspected theft, an NHS trust-employed prescriber should report this immediately to whoever issued the prescription forms (normally the hospital pharmacy). They will inform the local counter fraud specialist at the trust. The prescriber should give details of the number of prescription forms stolen, their serial numbers, and where and when they were stolen. Thereafter, hospital-based prescribers should follow local instructions following the loss or theft of prescription forms - this may include

writing and signing all prescriptions in a particular colour (usually red) for a period of two months.

27. It is the responsibility of the employer to ensure that:

- prescription pads are retrieved from supplementary prescribers who leave their employment for whatever reason. NB. Prescription pads should be securely destroyed e.g. by shredding and putting into confidential waste. It is advisable to record first and last serial numbers of the pads destroyed. Failure to recover prescription forms may potentially incur a cost, as any item prescribed on forms after supplementary prescribers have left employment would still be charged to the appropriate budget.
- to ensure that no further prescription pads are ordered for a prescriber who has left their employment or who has been suspended from prescribing duties, and
- to recover, record and securely destroy all unused prescription forms relating to that prescriber.

**NB All of the above requirements highlight the need for clear channels of communication, particularly between GP practices/PMS pilots and PCTs.**