Primary and Community Care Directorate
Primary Care Division

The Scottish Government

CEL 31 (2009)

10 July 2009

Addresses

For action

Chief Executives NHS Boards

Chief Executive, NHS National Services Scotland

NHS Board Prescribing Leads

For information

Chief Executive, State Hospital Board for Scotland

Chief Executive, NHS Health Scotland

Chief Executive NHS 24

Chief Executive, NHS Education for Scotland

Chief Executive, Quality Improvement Scotland

Counter Fraud Services

Enquiries to:

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St Andrew's House
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Dear Colleague

ALLIED HEALTH PROFESSIONAL (AHP) SUPPLEMENTARY PRESCRIBING STATIONERY ARRANGEMENTS

Summary

1. This circular advises NHS Boards of:

    - The local registration arrangements for Allied Health Professional (AHP) prescribers; and
    - the arrangements for obtaining supplies of prescription stationery.

Background

2. Circular HDL(2005) 17, issued on 14 April 2005 and HDL(2005) 30, issued on 4 July 2005, advised of;

    - the amendment to the definition of "supplementary prescriber" to include additional categories of health care professional who may prescribe as a supplementary prescriber; and
    - other mechanisms available for the prescribing, supply and administration of medicines.

3. Guidance on ordering stationery is attached at Annex A and guidance for AHP supplementary prescribing within NHSScotland is attached at Annex B.

Action

4. NHS Boards are asked to:

    - put into effect the arrangements detailed in the attached guidance; and

- ensure that all prescribing and dispensing contractors receive a copy of this letter and guidance, in particular AHP prescribers, community pharmacists and general medical practitioners.

Yours sincerely

GRAEME DICKSON
Director, Primary and Community Care Directorate

AHPs Registration and Prescription Stationery

It has been agreed that with effect from 13th July 2009 Allied Health Professionals will be able to prescribe using the GP10 (NMP) prescription form after the necessary training and registration has been undertaken.

The flow chart at **Appendix A** sets out the steps necessary to register locally as an AHP prescriber.

AHP prescribers will be required to register with the local NHS Board and an application form for this purpose (ISD (NMP) 1) is attached at **Appendix B**. Application forms are also available from NHS Boards or can be accessed at http://www.isdscotland.org/isd/1038.html For supplementary prescribers working across more than one GP practice, it is necessary to complete one form per practice

Completed application forms should then be authenticated and forwarded by the Board to NSS (ISD Healthcare Information Group eVADIS) who will allocate each AHP prescriber with a unique prescriber code for each practice that they work for and confirm registration.

Once an AHP prescriber has been allocated a prescriber code, a supply of prescriptions forms GP10 (NMP) can be ordered by the NHS Board from NSS Practitioner services Division using order form PSD7/PSD9 – copy attached at **Appendix C**.

A draft copy of the GP10 (NMP) and HBP (NMP) are attached at **Appendix D**

AHPs prescribing within a primary care settings will prescribe using the form annotated GP10 (NMP). The form will be pre-printed with the prescriber's name, prescriber type (e.g. podiatrist), GP practice address, contact telephone number, prescriber code and HPC number

Supplementary prescribers who prescribe across more than one GP practice will be supplied with 2 different types of prescription pads. Pads issued in respect of the "principle prescribing practice" i.e. the practice for whose patients the greatest number of prescriptions will be written, will be pre-printed with all the details above.

Prescription pads used for patients registered with any other GP practice will be printed with the prescriber's name, prescriber type (e.g. podiatrist), the Health Board cipher and the HPC number. Prescribers will need to write the appropriate prescriber code on each prescription.

Hospital Prescription Stationery

Prescriptions can be written for hospital inpatients or outpatients using:

- hospital inpatient prescription forms or sheets – used for inpatients and discharge supplies only;
- internal hospital prescription forms – used for outpatients in cases where the hospital pharmacy dispenses the prescription;

- HBP (NMP) prescription forms, used for prescriptions written by a hospital prescriber for dispensing by a community pharmacist

Once registered with the HPC as a supplementary prescriber, an AHP should inform his/her local prescribing lead who will order a supply of HBP(NMP) forms by completing PSD 9 (attached at **Appendix C**) and forwarding to:

Practitioner Services, Kirkton Campus, 3 Bain Square, Livingston, EH54 7DQ.

Each prescription form will be pre-printed with their name, the hospital/department prescriber code and the hospital address and contact telephone number. Prescribers will need to write the appropriate prescriber code and HPC number on each prescription.

Copies of the AHP supplementary prescriber prescription forms GP10 (NMP) and HBP (NMP) are attached for information at **Appendix D**

Non-NHS Employees

A non-NHS supplementary prescriber cannot prescribe using GP10 (NMP) or HBP (NMP) prescription forms unless the organisation they work for has an arrangement with an NHS provider which allows the non-NHS organisation to use NHS community pharmacy services. In these circumstances the NHS provider should organise the supply of NHS prescription forms (and obtain from ISD eVADIS the relevant prescribing code (s)) for the non-NHS organisation.

General Administrative Arrangements

Stationery supplies for NHS prescribers are normally ordered on an ad-hoc basis and usually take four weeks from order to delivery. Prior to the introduction of a new version of the prescription form. Practitioner Services Division (PSD), with help from NHS organisations, carry out a review of current prescribers. In order to avoid errors the PSD Master List should be updated electronically and sent to: prescriberstationery@psd.csa.scot.nhs.uk

Printing Errors

Where a printing error has occurred the NHS Board should return the prescription forms to Practitioner Services who will arrange for a new supply of prescription forms.

Security of Prescription Stationery

The security of prescription forms is the responsibility of both the NHS organisation and the prescriber. A local policy should be in place to monitor the use of prescription forms to deter theft and fraudulent use. It is advisable to hold minimal stocks of prescription stationery. This reduces the number of forms vulnerable to theft and, as prescription stationery is normally reviewed annually, helps to keep stocks up to date and reduce wastage. More information on security will be set out in the guidance on AHP supplementary prescribing within NHSScotland.

Loss of Prescription Forms

Practitioner Services Division (PSD) should be contacted about prescriptions ordered, but not delivered by contacting;

Mrs S Louden
Practitioner Services Division
3 Bain Square
Livingston
EH54 7DQ
Tel: 01506 705100
Fax: 01506 705191
Email: prescriberstationery@psd.csa.scot.nhs.uk

APPENDIX A

PRESCRIPTION STATIONERY: NON MEDICAL PRESCRIBING SERVICE

Non Medical Prescriber (or employing/hosting organisation)

Requests Non Medical Practitioner Registration or Change of Circumstances Form ISD (NMP) 1 from local NHS Board, or downloads from http://www.isdscotland.org/isd/1038.html and sends completed form to the NMAHP Prescribing Lead at relevant local NHS Board.

↓

NHS Board

Authenticates information provided. NMAHP Prescribing Lead sends completed form to NSS (ISD Healthcare Information Group eVADIS).

↓

Information Services Division (ISD)

Allocates prescriber code. Confirms registration. Registers prescriber with eVADIS.

↓

NHS Board

Sends to NSS Practitioner Services form PSD7/PSD9 requesting supply of GP10 (NMP) and/or HBP (NMP) prescription pads.

↓

Practitioner Services Division (PSD)

Arranges printing of prescription pads.

↓

NHS Board

Receives prescription pads. Forwards pads to prescriber (or employing/hosting organisation).

APPENDIX B

Form: ISD (NMP) 1

NON-MEDICAL PRESCRIBER REGISTRATION OR CHANGE OF CIRCUMSTANCES

Return form to: **Healthcare Information Group, Area 114c, 1st Floor, Gyle Square, 1 South Gyle Crescent, Edinburgh EH12 9EB**
mailto:evadis@isd.csa.scot.nhs.uk

Please tick appropriate box:

☐	New Prescriber	**(Complete all sections)**
☐	Change of name	**(Complete sections A, B and D)**
☐	Prescribing activity ends	**(Complete all sections)**
☐	Additional medical practice	**(Complete all sections)**
☐	Change of medical practice	**(Complete all sections)**
☐	Additional Prescriber Type	**(Complete all sections)**
☐	Change of Prescriber Type	**(Complete all sections)**

Prescribers working across more than one GP practice must fill in one form for each practice.

SECTION A: Prescriber Details

		New Prescriber Registration	Change of Circumstances
1	Surname		
2	Forename and Initials		
3	Job Title		
4	Professional registration number		
5	Unique Prescriber Code	[redacted]	
6	Prescribing planned start date		
7	Prescribing end date	[redacted]	
8	Prescriber Type such as, Podiatrist, Optometrist, Radiographer, Physiotherapist or other Non-Medical Prescriber type		

SECTION B: GP Practice Details

		New Prescriber Registration	Change of Circumstances
1	Practice Code		
2	Practitioner / Senior GP name		
3	Practice Address		

Is this the Prescribers principal prescribing practice i.e. the practice where the majority of patients for whom they prescribe are registered? **YES / NO**

Please continue overleaf

SECTION C: NHS Organisation Details

1 NHS organisation	
2 Address	
3 Contact Telephone Number	

SECTION D: To be completed by Health Board Official responsible for notifying registration:

Name (capital letters please): _____

Telephone number: _____

Address: _____

_____

_____

Signature: ……..…..

Date: ……

_____

HIG use only	**Prescriber code:**	**Date issued:**

APPENDIX C

PSD 7

SUPPLEMENTARY PRESCRIBER: ORDER FORM for GP10(NMP) for PODIATRISTS, RADIOGRAPHERS & PHYSIOTHERAPISTS

Form to be completed by AHP Lead and returned to:

Practitioner Services, Kirkton Campus, 3 Bain Square, Livingston, EH54 7DQ
Tel: 01506 705 101 Fax: 01506 705 191 e-mail: prescriberstationery@psd.csa.scot.nhs.uk

Please tick appropriate box

Podiatrist Prescriber ☐

Prescriber Code
(If Part Printed Health Board Cipher only) ☐

HPC Registration No. ☐

Radiographer Prescriber ☐

Surname: …… **Initial**: ……

Physiotherapist Prescriber ☐

Principal Address (for pre-printing on pads)

……

……

……

Part printed Pads
(If part printed pads only, please circle which Profession above) ☐

Post Code…… **Quantity (Minimum 5)** ☐

Contact Telephone Number:……

From:

Address for delivery of pads: (NHS organisation stores or pharmacy department/ or direct to the prescriber's address where agreed by NHS employer)**:**

……
……
……
Post **Code:** ……..

Signed: …… (Authorised Signatory) **Date:** ……

Print Name: …… **Telephone Number:**……..

Version 3 6.4.09

PSD 9
SUPPLEMENTARY PRESCRIBER: ORDER FORM for HBP(NMP) for PODIATRISTS, RADIOGRAPHERS & PHYSIOTHERAPISTS

Form to be completed by AHP Lead and returned to:

Practitioner Services, Kirkton Campus, 3 Bain Square, Livingston, EH54 7DQ
Tel: 01506 705 101 Fax: 01506 705 191 e-mail: prescriberstationery@psd.csa.scot.nhs.uk

Please tick appropriate box

Podiatrist Prescriber ☐

Prescriber Code
(If Part Printed Health Board Cipher only) ☐

HPC Registration No. ☐

Radiographer Prescriber ☐

Surname: …… **Initial**: ……

Physiotherapist Prescriber ☐

Principal Address (for pre-printing on pads)

……..
……
……

Part printed Pads
(If part printed pads only, please circle which Profession above) ☐

Post Code…… **Quantity (Minimum 5)** ☐

Contact Telephone Number:……

From:

Address for delivery of pads: (NHS organisation stores or pharmacy department/ or direct to the prescriber's address where agreed by NHS employer)**:**

……
……
……
Post **Code:** ……..

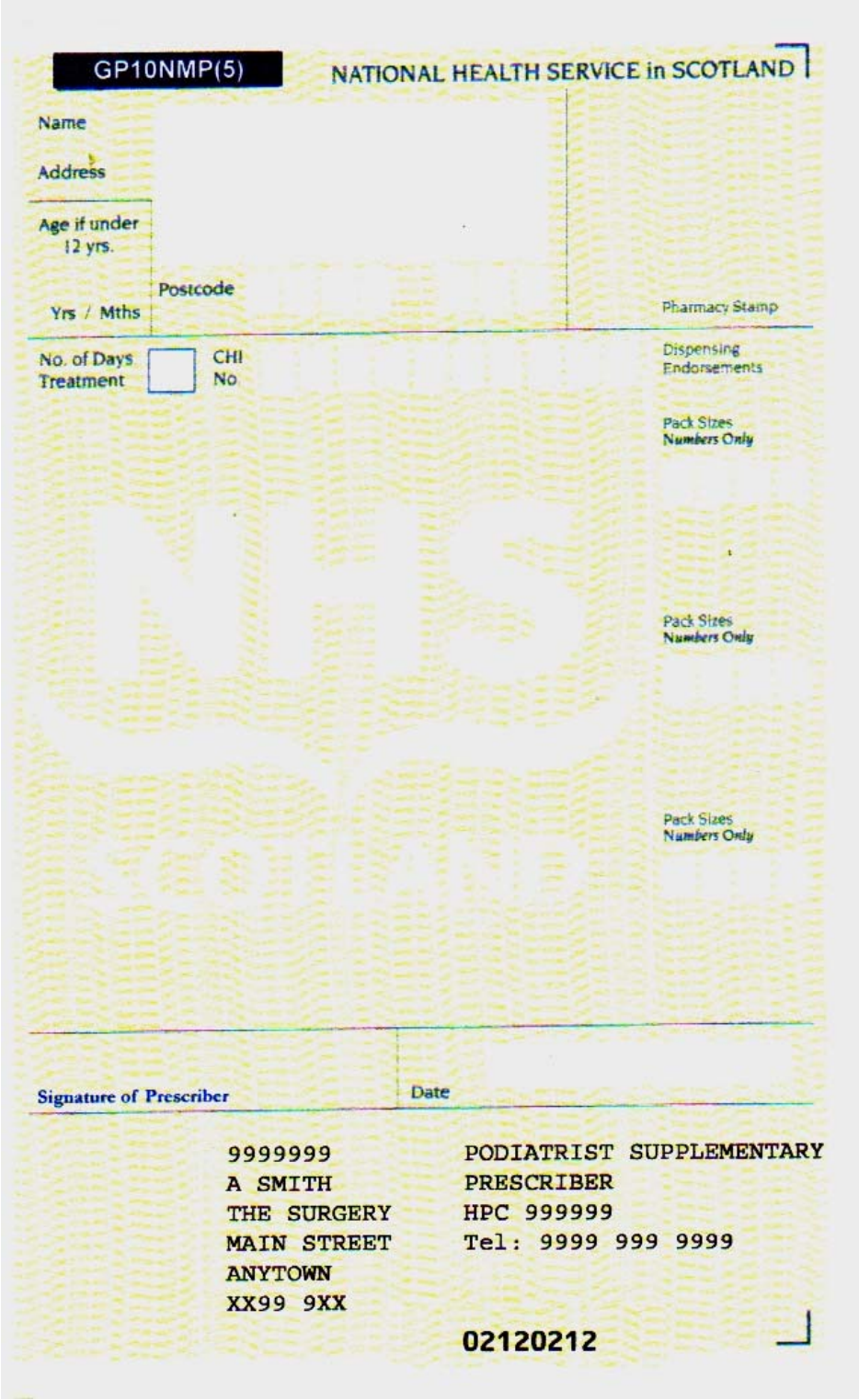
Signed: …… (Authorised Signatory) **Date:** ……

Print Name: …… **Telephone Number:**……

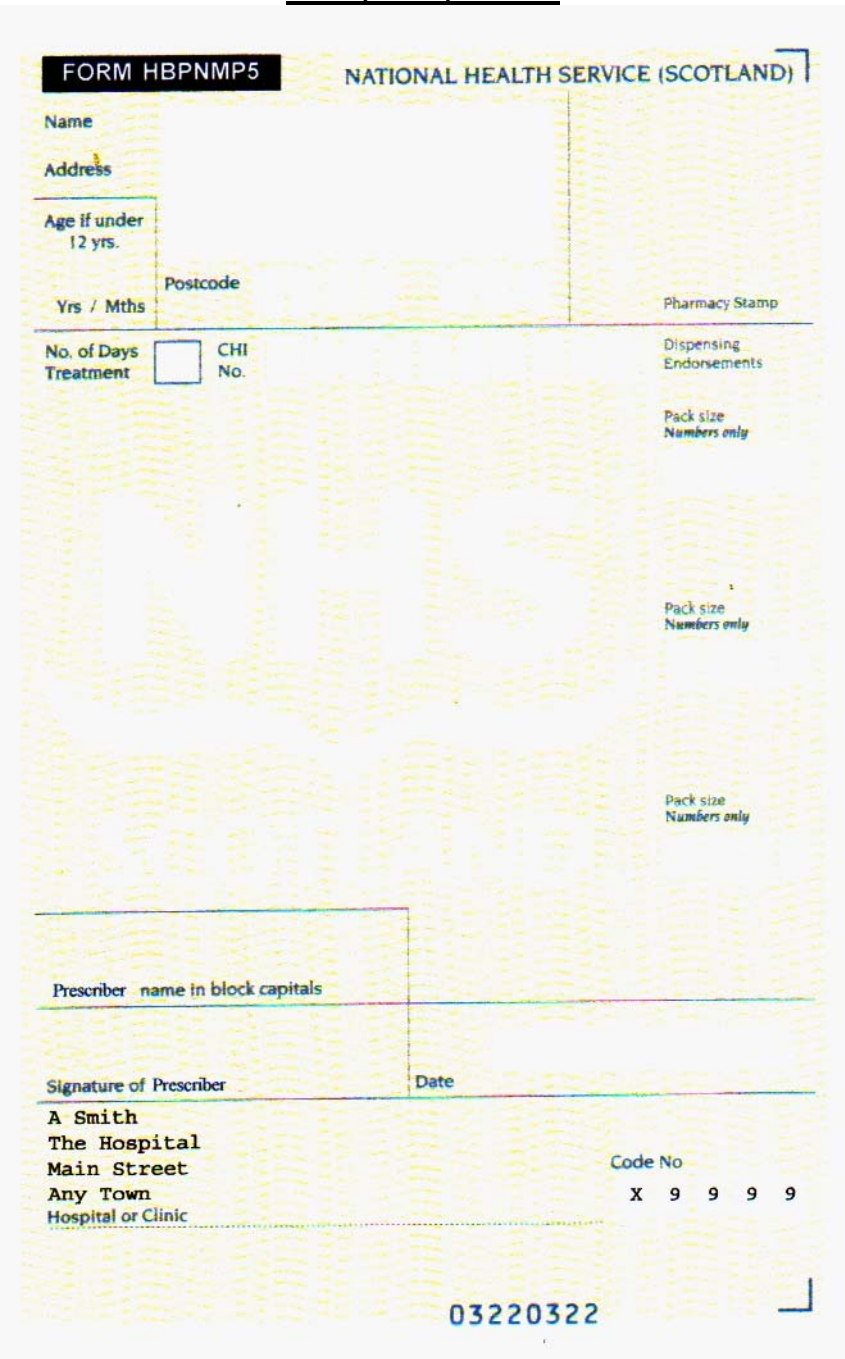
Version 2 12.2.09

APPENDIX D

GP10 (NMP) FORM



HBP (NMP) FORM



FORM HBPNMP5

NATIONAL HEALTH SERVICE (SCOTLAND)

Name

Address

Age if under 12 yrs.

Yrs / Mths

Postcode

Pharmacy Stamp

No. of Days Treatment

CHI No.

Dispensing Endorsements

Pack size
Numbers only

Pack size
Numbers only

Pack size
Numbers only

Prescriber name in block capitals

Signature of Prescriber

Date

A Smith
The Hospital
Main Street
Any Town
Hospital or Clinic

Code No
X 9 9 9 9

03220322

Annex B

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Supplementary Prescribing by Chiropodists/Podiatrists, Physiotherapists and Radiographers within NHSScotland

A Guide for Implementation

Scottish Government

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.scotland.gov.uk

This guide has been prepared for:

- NHS Boards
- NHS Prescribing Leads
- General Practitioners
- Pharmacists
- Community Services Pharmacists employed by, or contracted to, NHS organisations
- Higher Educational Institutions providing Allied Health Professional education
- Patient/Carer Groups
- Prison Healthcare Services
- Defence Medical Services

This guide for implementation has been produced to assist the allied health professionals (AHPs), namely podiatrists, physiotherapists and radiographers to be able to train as supplementary prescribers.

It will be for NHS Boards to select which of their AHPs should undertake training and preparation for supplementary prescribing in light of patient and service need and local priorities.

The introduction of prescribing into AHP practice provides a unique opportunity to jointly consider the education, strategic and operational needs of prescribers who are nurses, midwives and AHPs.

The Scottish Government has developed a strategy to set out the infrastructure needed to drive NMAHP prescribing forward and this will be published later this year. The strategy will provide NHS Boards with a framework from which they can develop prescribing services that are right for patients and the public, right for NMAHPs and right for other health professionals.

Further general guidance on supplementary prescribing may be found using the following link:

http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/non-medicalprescribing/policy

INTRODUCTION

1. This guide sets out the administrative and procedural steps needed to enable the following professions to supplementary prescribe:

   Registered podiatrists

   Registered physiotherapists

   Registered radiographers (diagnostic and therapeutic)

   Where the term 'AHP' is used, it refers to those allied health professionals currently permitted in legislative terms to train as supplementary prescribers.

Scope of this guidance and effect on devolution

2. This guide sets out the steps required to implement supplementary prescribing for AHPs in Scotland. Medicines legislation permitted the introduction of supplementary prescribing for AHPs across the UK in 2005 and Ministers in Scotland agreed that supplementary prescribing in Scotland will be extended to include the above group of AHPs.

BACKGROUND

General

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

   - the **independent prescriber** who would be responsible for the assessment of patients with undiagnosed conditions and for the decisions about their clinical management required, including prescribing;

   - the **dependent or supplementary 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 patient's needs. The Review recommended that there should be provision for regular clinical review by the assessing clinician.

4. In a press release on 4th May 2001, the Minister for Health and Community Care announced the Scottish Executive's (now the Scottish Government) intention to allow supplementary prescribing by nurses and prescribing by other professions such as pharmacists following the enactment of the Health and Social care Bill. Ministers subsequently decided that the greatest benefit to the NHS and to

patients would be the introduction of supplementary prescribing by nursing professions and pharmacists, following diagnosis by a doctor.

5. This was followed by a joint formal consultation by the Department of Health and the Medicines and Healthcare products Regulatory Agency (MHRA) in 2004. The results of the consultation were considered at meetings of the Committee on the safety of Medicines and the Medicines Commission in 2004. Changes to regulations in spring of 2005 have enabled AHPs from chiropody/podiatry, physiotherapy and radiography to be eligible to train as supplementary prescribers.

What is supplementary prescribing?

6. 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

7. 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 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 for NHS regulations allow supplementary prescribing by suitably trained nurses, pharmacists and the aforementioned AHPs.

Aim of supplementary prescribing

8. Supplementary prescribing in nursing and pharmacy professions has proved to be successful, providing quicker and more efficient access to medicines, and making the best use of the skills of those professionals. It has allowed the management of a number of patients with long-term conditions to be managed effectively and efficiently by those professions. The benefits accrued are easier and quicker access to medicines, improved symptom control, improved morbidity and reduction of doctor's workload, freeing up their time to concentrate on patients with more complicated conditions and more complex treatments. Time spent initially developing Clinical Management Plans (CMPs) is time saved when the patient returns for review to the supplementary prescriber rather than the doctor.

9. Supplementary prescribers prescribe in partnership with a doctor or a dentist (the independent prescriber). AHPs are able to prescribe all medicines (including unlicensed medicines) and Controlled Drugs. They may prescribe for the full range of medical conditions, provided they do so within their own area of clinical competence, under the terms of a patient-specific 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 prescriber.

HOW SUPPLEMENTARY PRESCRIBING WILL WORK

General principles

10. At the moment, the independent prescriber must be a doctor or dentist. It is for the independent prescriber to determine which patients may benefit from supplementary prescribing and the medicines that may be prescribed by the supplementary prescriber under the CMP. S/he will clearly need to take account of the professional relationship between the independent and supplementary prescriber as well as the experience and areas and degree of expertise of the supplementary prescriber when coming to a decision.

11. Supplementary prescribing is a partnership between the independent and the supplementary prescriber who, between them, should draw up and agree an individual CMP with the patient for their condition(s) before supplementary prescribing begins. However they are developed, they must contain the information set out in paragraph 40 and they must be patient-specific.

12. 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 agree how to maintain communication and that communication must be maintained, while the supplementary prescriber is reviewing and prescribing for that patient. They should ideally jointly carry out the formal clinical review within an agreed time – normally within a maximum of 12 months of the start of the CMP (Periods of 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 to be expected during a longer time 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 by 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.`

13. 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 GP), the supplementary prescriber may not continue to prescribe, unless s/he negotiates and records in the patient's record a new agreement to enter the partnership with the new independent prescriber.

Characteristics of supplementary prescribing

14. 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 the setting of parameters for the CMP, although they need not personally draw it up.

- 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. All guidelines referred to should be readily accessible to the supplementary prescriber when managing the patient's care.

- 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 12 months (and much less than this if antibiotics are to be included in the CMP). However, as stated in paragraph 12, 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. Local arrangements around this issue will be determined within NHS Board prescribing policies.

15. The key to safe and effective supplementary prescribing is the relationship between the individual independent prescriber and the individual supplementary prescriber.

16. The 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 they 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

17. 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
- 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
- Provide 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 the patient's condition
- Sharing the patient's record with the supplementary prescriber
- Reporting adverse incidents within local risk management or clinical governance schemes

18. The supplementary prescriber is responsible for:

- Prescribing for the patient in accordance with the CMP. Altering the medicines prescribed, within the limits set out in the CMP, if monitoring 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
- 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 para 12) or is they feel the patient's condition no longer falls within their competence
- Recording prescribing and monitoring activity contemporaneously in the shared patient record or as soon as possible – ideally within 24 to 48 hours. Clearly, if electronic records are accessible, these can be completed immediately after consultation

Working together

19. Independent and supplementary prescribers must be willing and able to work together to assume the specific responsibilities listed above.

20. Independent and supplementary prescribers may work in more than one prescribing partnership, providing that in each case they work as described above.

The process

21. 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 educational qualification is recorded on the relevant professional register.

- Reach agreement with their employer that supplementary prescribing should form part of their professional; responsibilities.

- Agree to work within the local policy and clinical governance arrangements for supplementary prescribing within their organisation (see A Safe Prescription, Scottish Government, 2008)

- Make arrangements with their employer and/or the independent prescriber for access to prescription pads or other mechanisms for prescribing that are appropriate to the setting, for example patient/s medicine prescription sheets in hospitals.

- Arrange for access to an identified budget to meet the costs of their prescriptions.

Conditions and health needs that can be included

22. 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 chronic medical conditions or health needs affecting patient. However, acute episodes occurring within chronic conditions may be included in these arrangements provided they are included in the CMP.

Patient consent

23. 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 obtained. [1]

24. The agreement of the patient to the prescribing partnership should be recorded in the CMP and patient record. Without such an agreement, supplementary prescribing may not proceed.

TRAINING AND PREPARATION FOR SUPPLEMENTARY PRESCRIBING

25. Only the AHPs named on the front of this document, who are registered on their professional register, and who have successfully completed an approved education programme may practice as supplementary prescribers.

Selection of AHPs to be trained

26. The selection of AHPs who will receive training in prescribing is a local decision, in the light of local strategies for the implementation of non medical prescribing (NMP). No AHP shall be required to undertake training unless s/he wishes to do so or it is included in their job description. All individuals selected for training must have the opportunity to prescribe in the post they will occupy on completion of training.

27. In addition to fulfilling the legal criteria for eligibility to prescribe, applicants who are selected for prescribing will need:

- To meet the entry requirements for the higher educational institutes providing the courses.

- To have at least three years post-registration experience.

- To have the support of their employer to confirm that;

  - their post is one in which they will have the need and opportunity to practice as a supplementary prescriber.
  - where appropriate, they will have access to a budget to meet the cost of the prescriptions on completion of the course.
  - they will have access to continuing professional development (CPD) opportunities on completion of the course.

28. The two key principles that should be used to prioritise potential applicants are:

- maximum benefit to patients and the NHS in terms of quicker, safe and more efficient access to medicines for patients

- the most appropriate use of skills of health professionals

Only education programmes that are jointly approved by the HLSP and the Health Professions Council (HPC) can lead to annotation on professional registers. Guidance from NHS Education Scotland (NES) on education programmes in Scotland offers full information about the programmes. This is available via the NES website: www.nes.scot.org.uk

Preparation for supplementary prescribers

29. AHPs preparing to be supplementary prescribers will undertake a joint programme of preparation with nurses and midwives at degree level (level 9, 10 or 11). The programmes comprise of the equivalent of 26 taught days with a Higher Education Institution plus 12 days "learning in practice", during which a designated medical practitioner will provide the student with supervision, support and opportunities to develop competence in prescribing practice. The programme of preparation may be spread out over a period of three to six months. Many HEIs provide a distance learning programme that consist of a mandatory 8 face-to-face taught days 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 provided in paragraph 75

30. It will be for NHS organisations to determine which AHPs to put forward for the programme of training and preparation.

31. In addition to the time spent on the formal programme, it is important that employers of AHPs undertaking the programme recognise the demands of private study and provide support where necessary. Employers should also provide mentoring.

32. AHPs will be required to pass all components of the assessment, prior to HPC registration to indicate that they have successfully completed the programme and have qualified as supplementary prescribers.

33. Funding for the educational programme is currently available centrally. Funding is granted retrospectively on proof of successful completion of the programme. Funding should be claimed through the local prescribing lead. NHS employers may also, of course, utilise their own training funds for this purpose.

Preparation for independent prescribers

34. It is highly desirable that independent prescribers who wish to take part in a supplementary prescribing partnership first undertake a short period of preparation related to the nature of supplementary prescribing and their responsibilities in the partnership. This will not necessarily require attendance at a HEI: learning materials may be made available for use in the workplace.

35. All 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 drugs, dressing and appliances.

EVALUATION, AUDIT AND CLINICAL GOVERNANCE OF SUPPLEMENTARY PRESCRIBING

36. Supplementary prescribing needs to take place within a framework of clinical governance. Clinical supervision models should be agreed at local level, taking

account of other staff support mechanisms and resources. It should be monitored and evaluated regularly

37. A general overview of supplementary prescribing arrangements should be carried out as part of the overall prescribing monitoring arrangements

38. The supplementary prescriber together with his or her employer must put in place specific actions regularly to evaluate the safety, effectiveness, appropriateness and acceptability of their prescribing

39. Other assistance with identifying audit methodologies and interpreting findings should be available through the employing organisations normal clinical governance mechanisms

THE CLINICAL MANAGEMENT PLAN (CMP)

Some templates have been produced to help the NHS to develop CMPs more easily, although these are not mandatory. They are available on the Scottish Government website http://www.scotland.gov.uk/Publications/2003/12/18513/28933 under Annex B and C and are also attached as **Annex A** and **B** to this Guide

40. The CMP is the foundation stone of supplementary prescribing. Before supplementary prescribing can take place, it is obligatory for an agreed CMPO to be in place (written or electronic) relating to a named patient and to the 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 CMP relates
- The illness or conditions which may be treated by the supplementary prescriber.
- The date on which the plan is to take affect, and the date 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 and administered under the plan.
- Any restrictions or limitations as to the strength or dose of any medicine which may be prescribed or administered under the plan, and in any period of administration or use of any medicine or appliance which may be prescribed under the plan.
- The arrangements in place for communication between independent and supplementary prescribers and for record maintenance.

[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 guideline also needs to be easily accessible].

- Relevant warnings about known sensitivities of the patient to, or known difficulties of the patient with, particular medicines or appliances.

- The arrangements for notification of:

  a) suspected or known reactions to any medicine which may be prescribed or administered under the plan, and suspected or known 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 56-58 about Adverse Drug Reactions]

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

41. 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.

42. Following diagnosis by the independent prescriber, the independent and supplementary prescriber will probably need to discuss the CMP before the document itself is prepared. Either prescriber may draft the CMP; however both must formally agree to the CMP before supplementary prescribing can begin. The agreement of the patient must also be sought, and that agreement recorded in the CMP. Without it, supplementary prescribing cannot proceed.

43. The independent and supplementary prescriber must share access to, consult and use, the same common patient record. Shared electronic records are ideal, but existing paper records or patient-held records can be used. The CMP may need to contain different levels of detail, if the independent and supplementary prescribers work in different locations (e.g. a hospital-based independent prescriber and at outreach supplementary prescriber in the patient's home).

44. It is for the independent prescriber to determine the extent of the responsibility he or she wishes to give the supplementary prescriber under the CMP. The independent prescriber will clearly 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.

45. The CMP comes to an end:

- At any time at the discretion of the independent prescriber.
- At the request of the supplementary prescriber.
- At the time specified for the review of the patient (unless it is renewed by both prescribers at the time).
- Where there is a sole independent prescriber and he or she is replaced for whatever reason. In those circumstances the CMP must be reviewed by their successor.

MEDICINES PRESCRIBABLE UNDER SUPPLEMENTARY PRESCRIBING ARRANGEMENTS

46. The CMP may include General Sales List (GSL), Pharmacy (P), or Prescription Only Medicines (POMs) or Controlled Drugs prescribable within the NHS. 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 licensed indications (i.e. "off-label" use), provided that the product is licensed for use in the UK. 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) may be included in the CMP only where:
  - a clinical trial is being undertaken under a clinical trials certificate or an exemption; and
  - their use has the joint agreement of both prescribers and the status of the drug is recorded in the CMP.

47. The independent prescriber will need to be aware of the high risk nature of many drugs prescribed under local shared 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 to take part in such an arrangement.

48. A supplementary prescriber must not agree to prescribe any medicine of s/he feels that his/her knowledge of the medicine s/he may be asked to prescribe falls outside of his/her area of competence.

THE PATIENT REVIEW

49. 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 set a new date for review. Prescribing by the supplementary prescriber after the date of the 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

50. 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 GP10A stock order system.

Informing patients

51. 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 necessary items for their care.
A Scottish Patient Information Leaflet will be made available in the near future.

Prescribing for self, family and friends

52. This is a matter for the independent prescriber to decide when setting up the CMP. However it is strongly recommended that (as for doctors and dentists) supplementary prescribers should, whenever possible, not be placed in the position of prescribing for close family members, as judgement may be impaired and important clinical examination may be difficult/impossible. They must not prescribe for themselves.

PATIENT RECORDS

53. All AHPs are required to keep contemporaneous records that are unambiguous and legible. The prescription details, together with other details of the consultation with the patient, should be entered into the record shared with the independent prescriber as soon as possible and preferably contemporaneously. It should be marked to indicate that it is the prescription of the supplementary prescriber, and contain the name of the supplementary prescriber. The maximum time to be allowed between writing the prescription and entering the details into the general record is for local negotiation, but best practice suggests that this should be immediately. Only in exceptional circumstances (e.g. the

intervention of a weekend of public holiday) should this period exceed 48 hours from the writing of the prescription. Arrangements for the sharing of patient records should be put in place at the same time as the supplementary partnership is set up. The record of the AHPs prescription should also be entered into the AHP record (where a separate AHP record exists) at the time of writing.

54. It is recommended that the record clearly indicates the date, the name of the prescriber, the name of the item prescribed and the quantity prescribed (dose, frequency and treatment duration). For medicinal preparations, items to be ingested or inserted into the body, it is recommended that the name of the prescribed item, the strength (if any) of the preparation, the dosing schedule and the route of administration is given, e.g. paracetamol oral suspension 120mg/5ml, 5ml to be taken four hourly by mouth as required for pain, maximum of 120mls in any 24 hours. For topical medicinal preparations, the name of the prescribed item, the strength (if any). The quantity to be applied and frequency of application should be indicated. For dressings and appliances, details of how to be applied and how frequently changed are useful. It is recommended that the advice given on GSL (also known as "over the counter") items be recorded, although this is not mandatory.

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

ADVERSE REACTION REPORTING

56. If a patient suffers a suspected adverse reaction to a prescribed, over-the-counter (GSL) or herbal medicine, the adverse reaction should be reporter via the Yellow Card Scheme. The Yellow Card Scheme is a voluntary scheme through which healthcare professionals notify the MHRA Committee on the Safety of Medicines (CSM) of suspected adverse drug reactions (ADRs). The MHRA/CSM encourage the reporting of all suspected adverse reactions to newly licensed medicines that are under intensive monitoring (identified by a black triangle 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 are on the MHRA website www.mhra.gov.uk

57. 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 BNF). The supplementary prescriber should also inform the independent prescriber of any reported ADRs.

58. The bulletin "Current Problems in Pharmacovigilance", issued by the MHRA and the CSM, contains information and advice on drug safety issues. The bulletin is produced four times a year. All supplementary prescribers are encouraged to

consult the bulletin as a matter of routine. Copies are also available from the CSM's website, which can be found on www.mhra.gov.uk

Role of the National Patient Safety Agency (NPSA)

59. If a patient suffers harm due to an adverse incident involving medication or if harm could have been caused to the patient (a near miss), the incident or near miss should be reported by the supplementary prescriber using both local and national reporting systems. The NPSA was established in England in 2001 to improve the safety of NHS patient care, by promoting a culture of reporting and learning from adverse incidents across the NHS. The NPSA information is shared with devolved health services in Scotland and Wales. The Agency will develop, implement and manage a new reporting system, which will collect information on adverse incidents and near misses so that lessons can be learnt at local and national level. It will develop solutions to try to ensure that the same errors are not repeated. NHS Quality Improvement Scotland (NHSQIS) has a role within Scotland to liaise with NPSA in relation to patient safety issues

LEGAL AND CLINICAL LIABILITY

Liability of employer

60. Where an AHP 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 AHPs are individually and 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

61. All supplementary prescribers should ensure that they have professional indemnity insurance, for instance by means of membership of a professional organisation or trade union.

DISPENSING OF PRESCRIBED ITEMS

Dispensing doctors in Primary Care

62. When a GP practice is a dispensing practice, prescriptions from supplementary prescribers can be dispensed by the practice but only for the patients within that practice. Dispensing doctors cannot dispense prescriptions written by supplementary prescribers for patients of other practices.

63. Submitting prescription forms to Practitioner Services Division (PSD), dispensing practices should include them with their GP10 form count on their GP34 declaration and sort them as per existing instructions.

64. 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.

65. The rules for dispensing and reimbursement of supplementary prescribers' prescriptions are the same as for GP prescriptions.

VERIFICATION OF PRESCRIBING STATUS

Role of the pharmacist on verification of prescribing status

66. Dispensing pharmacists should ensure that they know the local procedure for resolving queries with the supplementary prescriber or their independent prescriber partner.

67. To enable pharmacists to check whether a prescription handed in for dispensing in bona fide, all NHS employers should keep a list of all supplementary prescribers employed by them. It is also recommended that the employing authority hold a copy of the prescriber's signature. Individuals should be prepared to provide specimen signatures to pharmacists, should they be required.

68. Registration status of an AHP may be obtained using the following link: www.hpc-uk.org/register

DISPENSING BY APPLIANCE CONTRACTORS

69. 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 a medicinal preparation (Appliance contractors cannot dispense medicinal preparations). Appliance contractors should submit as per their usual instructions.

URGENT DISPENSING

70. 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 via NHS organisations, local pharmacies, NHS 24 or police stations.

DISPENSING OF ITEMS IN WALES AND NORTHERN IRELAND

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

DISPENSING ITEMS AGAINST AN AHP PRESCRIPTION IN HOSPITAL PHARMACIES

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

Prescribing information

73. The Healthcare Information Group (HIG) within the Information and Statistics Division (ISD) provides information on prescribed items and costs to their NHS organisations in the form of routine reports and in response to ad hoc requests. Supplementary prescribers can expect to receive information via their NHS employer which will help monitor their prescribing.

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

OUTLINE CURRICULUM FOR TRAINING SUPPLEMENTARY PRESCRIBERS

75. In 2004, the Department of Health produced an Outline Curriculum for Training Programmes to prepare Allied Health Professionals as Supplementary Prescribers. This may be obtained at http://www.healthprofessionscouncil.com/assets/documents/100006C3education_and_training_committee_20050216_enclosure07i.pdf

MAINTAINING COMPETENCY IN PRESCRIBING – OUTLINE FRAMEWORK

76. Maintaining competency in prescribing – an outline framework to help AHP supplementary prescribers can be found at www.npc.co.uk/maintaincompinprescribing.htm

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	
Medicines that may be prescribed by SP:			
Preparation	Indication	Dose schedule	Specific indications for referral back to the IP
Guidelines or protocols supporting Clinical Management Plan:			
Frequency of review and monitoring by:			
Supplementary prescriber	Supplementary prescriber and independent prescriber		
Process for reporting ADRs			
Shared record to be used by IP and SP			

Agreed by independent prescriber(s)	Date	Agreed by supplementary prescriber(s)	Date	Date agreed with patient/carer

ANNEX B

Template CMP 2 (Blank):

For teams where the SP does not have co-terminus access to the medical records

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

Agreed by independent prescriber(s)	Date	Agreed by supplementary prescriber(s)	Date	Date agreed with patient/carer

PART 1: REGISTRATION FOR SUPPLEMENTARY PRESCRIBERS

Registration with the Healthcare Information Group (HIG) of the Common Services Agency Information & Statistics Division (ISD)

1. Supplementary prescribers employed in the NHS Primary Care sector must be registered with the Healthcare Information Group (HIG). Employers are asked to use form **ISD (NMP) 1** "Non Medical Prescriber: Registration or Change of Circumstances Form" for this purpose. (Form **ISD (NMP) 1** is reproduced at Appendix 1.)

2. Form **ISD (NMP) 1** should also be used to notify HIG of any new or changed circumstances (e.g. change of name) for all NMP prescribers. Stocks of **ISD (NMP) 1** can be obtained from http://www.isdscotland.org/isd/1038.html

3. The information requested on form **ISD (NMP) 1** includes:

- Supplementary prescriber's profession and name
- Supplementary prescriber's personal registration number with the HPC
- Details of the GP practice(s) where the supplementary prescriber's patients are registered
- Organisation for which prescriber works (where relevant).

NB. Employers must notify HIG of each GP practice whose patients are served by the supplementary prescriber and identify the "principal prescribing practice" i.e. the GP practice for whose patients the supplementary prescriber will write the most prescriptions.

4. On receipt of the correctly completed **ISD (NMP) 1** a prescriber code will be allocated and **ISD (NMP) 1** form will be returned to the local prescribing lead.

Changes to Prescriber Details

5. (a) It is the responsibility of employers to notify HIG without delay of all relevant changes to prescriber details, e.g. change of name on marriage etc. Form **ISD (NMP) 1** should also be used for this purpose. No changes can be made to prescription stationery until formal notification is received.

(b) Any changes of prescriber details should be passed to the relevant NHS Board administrator within 48 hours (excluding weekends or Bank Holidays). This information should be passed to HIG as specified in (a) above.

6. When completed, form **ISD (NMP) 1** should be sent by post to:

Healthcare Information Group, Area 114c, 1st Floor, Gyle Square, 1 South Gyle Crescent, Edinburgh, EH12 9EB.

Prescriber Ceases Employment / Prescribing

7. HIG must be advised immediately if a registered supplementary prescriber stops prescribing together with an appropriate reason e.g. because s/he has changed employer, retired, resigned, been suspended from the register or has had his/her approval as a prescriber withdrawn.

8. In this situation, prescribing stationary should be retrieved from the prescriber as a matter of urgency, and disposed of in accordance with the procedure outlined in Part 2, paragraph 2

9. Notification is also required when the prescriber's employer is contracted to provide services for other commissioning organisations.

10. Employers should annotate their lists of supplementary prescribers with the reasons for any changes to ensure an up-to-date record exists.

PART 2: PRESCRIPTION STATIONERY

AHP Prescribers – Primary Care

1. AHPs working in primary care settings will prescribe using the form annotated GP10 (NMP). The form will be pre-printed with the prescriber's name, prescriber type (e.g. podiatrist), GP practice address, contact telephone number, prescriber code and HPC number

2. Supplementary prescribers who prescribe across more than one GP practice will be supplied with 2 different types of prescription pads. Pads issued in respect of the "principle prescribing practice" i.e. the practice for whose patients the greatest number of prescriptions will be written, will be pre-printed with all the details above.

3. Prescription pads used for patients registered with any other GP practice will be printed with the prescriber's name, prescriber type (e.g. podiatrist), the Health Board cipher and the HPC number. Prescribers will need to write the appropriate prescriber code on each prescription.

Ordering GP10 (NMP) Stationery

4. On receipt of form ISD (NMP) 1 from HIG, the NMAHP Prescribing Lead will order a supply of stationery for the supplementary prescriber using form PSD7 which should be sent to Practitioner Services, Kirkton Campus, 3 Bain Square, Livingston, EH54 7DQ.

AHP Prescribers – Secondary Care

5. Prescriptions can be written for hospital inpatients or outpatients using:

- Hospital inpatient prescription forms or sheets – used for inpatients and discharge only

- Internal hospital prescription forms – used for outpatients in cases where the hospital pharmacy dispenses the prescription

- HBP (NMP) prescription forms, used for prescriptions written by a hospital prescriber for dispensing by a community pharmacist.

NB. Prescriptions written on internal hospital forms cannot be accepted for dispensing at community pharmacies.

Ordering HBP (NMP) Stationery

6. There is currently no requirement to inform HIG of changes to the details of hospital-based supplementary prescribers. This is because no prescriber details are pre-printed on HBP (NMP) forms.

7. Once registered with the HPC as a supplementary prescriber, an AHP should inform his/her local prescribing lead who will order a supply of HBP(NMP) forms by completing PSD 9 and forwarding to:

Practitioner Services, Kirkton Campus, 3 Bain Square, Livingston, EH54 7DQ.

8. Each prescription form will be pre-printed with their name, the hospital/department prescriber code and the hospital address and contact telephone number. Prescribers will need to write the appropriate prescriber code and HPC number on each prescription.

General Administrative Arrangements

9. Stationery supplies for NHS prescribers are ordered on an ad-hoc basis and usually take four weeks from order to delivery. Prior to the introduction of a new version of the prescription form a review of current prescribers is conducted by PSD with the help of NHS Boards/Trusts. In order to avoid errors each NHS Trust/Board is asked to complete the PSD Master List electronically.

Non-NHS Employees

10. A non-NHS supplementary prescriber cannot issue a GP10 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 which allows the non-NHS organisation to use NHS community pharmacy dispensing services. The NHS provider should organise the supply of GP 1- type prescription forms (and obtain the prescribing code (s) to be used) for the non-NHS organisation, if this is appropriate.

Prescription forms Ordered but not Delivered

11. Practitioner Services Division (PSD) should be informed about prescription stationery which is ordered but not delivered. Contact:

Ms S Louden Practitioner Services Division 3 Bain Square Livingston EH54 7DQ	e-mail: prescriberstationery@psd.csa.scot.nhs.uk Tel: 01506 705100 Fax: 01506 705191

Printing Errors

12. Where a printing error has occurred the NHS Board should return the prescription forms to Practitioner Services who will arrange for a new supply of prescription forms.

Security and Safe Handling of Prescription Forms: Good Practice

13. The security of prescription forms is the responsibility of both the employing organisation and the prescriber. Local policy should be established to monitor the use of prescription forms to deter theft and fraudulent use. Employers should record serial numbers of prescriptions issued to each prescriber, surgeries, clinics etc. It is also advisable to hold minimal stocks of prescription stationery. This reduces the number of forms vulnerable to theft, and helps to keep stock up-to-date. (Prescription forms are usually revised annually)

14. It is the responsibility of the employer to:

- Recover and record all unused prescription forms relating to supplementary prescribers who leave the employment for whatever reason.
- Send retrieval pads to stores with list of serial numbers.
- Securely destroy retrieved pads by e.g. shredding and placing in confidential waste.
- Ensure that no further prescription pads are ordered for a prescriber who has left their employment or who has been suspended from prescribing duties.

15. Each prescriber should keep a record of the serial numbers of prescriptions issued to him or her. The first and last serial numbers on each pad should be recorded. It is also good practice to record the number of the next unused prescription form on an in-use pad at the end of the working day. Such steps help to identify any forms that are lost or stolen.

16. Blank prescription forms must never be pre-signed and prescription pads should never be left unattended. In addition, prescription forms should not be left on a desk but placed in a locked drawer and produced when needed. Best practice is

to return all unused forms to stock at the end of the day or session. Prescriptions are less likely to be stolen from (locked) secure stationery cupboards than from desks, bags or cars.

17. All prescribers working in primary care should report the loss or theft of prescription stationery to their Primary Care Manager as soon as the theft/loss is discovered. The approximate number of prescription forms lost/stolen, their identification numbers, and where and when they were lost/stolen must be reported.

18. (a) The Primary Care Manager will immediately notify the Fraud Liaison Officer (FLO) who is responsible for informing local pharmacists and deciding on the action to be taken.

(b) The FLO should notify Counter Fraud Services on 01506 705200 who will maintain a database of lost/stolen prescription forms.

19. Following loss or prescription stationery the prescriber concerned will be asked to write and sign all prescription forms in a particular colour (usually red) for a period of two months. The employer will inform all pharmacies in there area and adjacent NHS areas of the name and address of the prescriber concerned, the approximate number of prescription forms lost/stolen and the period for which the prescriber will write In a specific colour. The advice will normally be put in writing within 24 hours, excepting weekends.

20. In the event of a loss or suspected theft within the acute sector, an employed prescriber should report this immediately to whoever issued the prescription forms (normally the hospital pharmacy) and the local fraud specialist. The prescriber should give details of the number of stolen scripts, their serial numbers, and where and when they were stolen. Thereafter hospital-based prescribers should follow local instructions following the loss/theft of prescription forms – this may include writing and signing all scripts in a particular colour (usually red) for a period of two months.

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

Form: ISD(NMP)1

NON-MEDICAL PRESCRIBER
REGISTRATION OR CHANGE OF CIRCUMSTANCES

Return form to: **Healthcare Information Group, Area 114c, 1st Floor, Gyle Square, 1 South Gyle Crescent, Edinburgh EH12 9EB**
mailto:evadis@isd.csa.scot.nhs.uk

Please tick appropriate box:

	New Prescriber	**(Complete all sections)**
	Change of name	**(Complete sections A, B and D)**
	Prescribing activity ends	**(Complete all sections)**
	Additional medical practice	**(Complete all sections)**
	Change of medical practice	**(Complete all sections)**
	Additional Prescriber Type	**(Complete all sections)**
	Change of Prescriber Type	**(Complete all sections)**

Prescribers working across more than one GP practice must fill in one form for each practice.

SECTION A: Prescriber Details

		New Prescriber Registration	Change of Circumstances
1	Surname		
2	Forename and Initials		
3	Job Title		
4	Professional registration number		
5	Unique Prescriber Code	[redacted]	
6	Prescribing planned start date		
7	Prescribing end date	[redacted]	
9	Prescriber Type such as, Podiatrist, Optometrist, Radiographer, Physiotherapist or other Non-Medical Prescriber type		

SECTION B: GP Practice Details

		New Prescriber Registration	Change of Circumstances
1	Practice Code		
2	Practitioner / Senior GP name		
3	Practice Address		

Is this the Prescribers principal prescribing practice i.e. the practice where the majority of patients for whom they prescribe are registered? **YES / NO**

Please continue overleaf

SECTION C: NHS Organisation Details

1 NHS organisation	
2 Address	
3 Contact Telephone Number	

SECTION D: To be completed by Health Board Official responsible for notifying registration:

Name (capital letters please) : _____

Telephone number: _____

Address: _____

_____

_____

Signature: ……..…..

Date:

_____

HIG use only	**Prescriber code:**	**Date issued:**

Appendix 2

PSD 7

SUPPLEMENTARY PRESCRIBER: ORDER FORM for GP10(NMP) for PODIATRISTS, RADIOGRAPHERS & PHYSIOTHERAPISTS

Form to be completed by AHP Lead and returned to:

Practitioner Services, Kirkton Campus, 3 Bain Square, Livingston, EH54 7DQ
Tel: 01506 705 101 Fax: 01506 705 191 e-mail: prescriberstationery@psd.csa.scot.nhs.uk

Please tick appropriate box

Podiatrist Prescriber ☐

Prescriber Code
(If Part Printed Health Board Cipher only) ☐

HPC Registration No. ☐

Radiographer Prescri ☐

Surname: …… **Initial**: …… ☐

Principal Address (for pre-printing on pads)

……

……

……

Post Code……

Part printed Pads
(If part printed pads only, please circle which Profession above) ☐

Quantity (Minimum 5)

Contact Telephone Number:……

From:

Address for delivery of pads: (NHS organisation stores or pharmacy department/ or direct to the prescriber's address where agreed by NHS employer)**:**

……
……..
……
Pos**t Code:** ……..

Signed: …… (Authorised Signatory) **Date:** ……
Print Name: …… **Telephone Number:**……..

Version 3 6.4.09

Appendix 3

PSD 9

SUPPLEMENTARY PRESCRIBER: ORDER FORM for HBP(NMP) for

PODIATRISTS, RADIOGRAPHERS & PHYSIOTHERAPISTS

Form to be completed by AHP Lead and returned to:

Practitioner Services, Kirkton Campus, 3 Bain Square, Livingston, EH54 7DQ
Tel: 01506 705 101 Fax: 01506 705 191 e-mail: prescriberstationery@psd.csa.scot.nhs.uk

Please tick appropriate box

Podiatrist Prescriber ☐

Prescriber Code
(If Part Printed Health Board Cipher only) ☐

HPC Registration No. ☐

Radiographer Prescrib ☐

Surname: …… **Initial**: …… ☐

Principal Address (for pre-printing on pads)

…….. **Part printed Pads** ☐
(If part printed pads
…… only, please circle which
Profession above)

……

Post Code…… **Quantity (Minimum** ☐

Contact Telephone Number:……

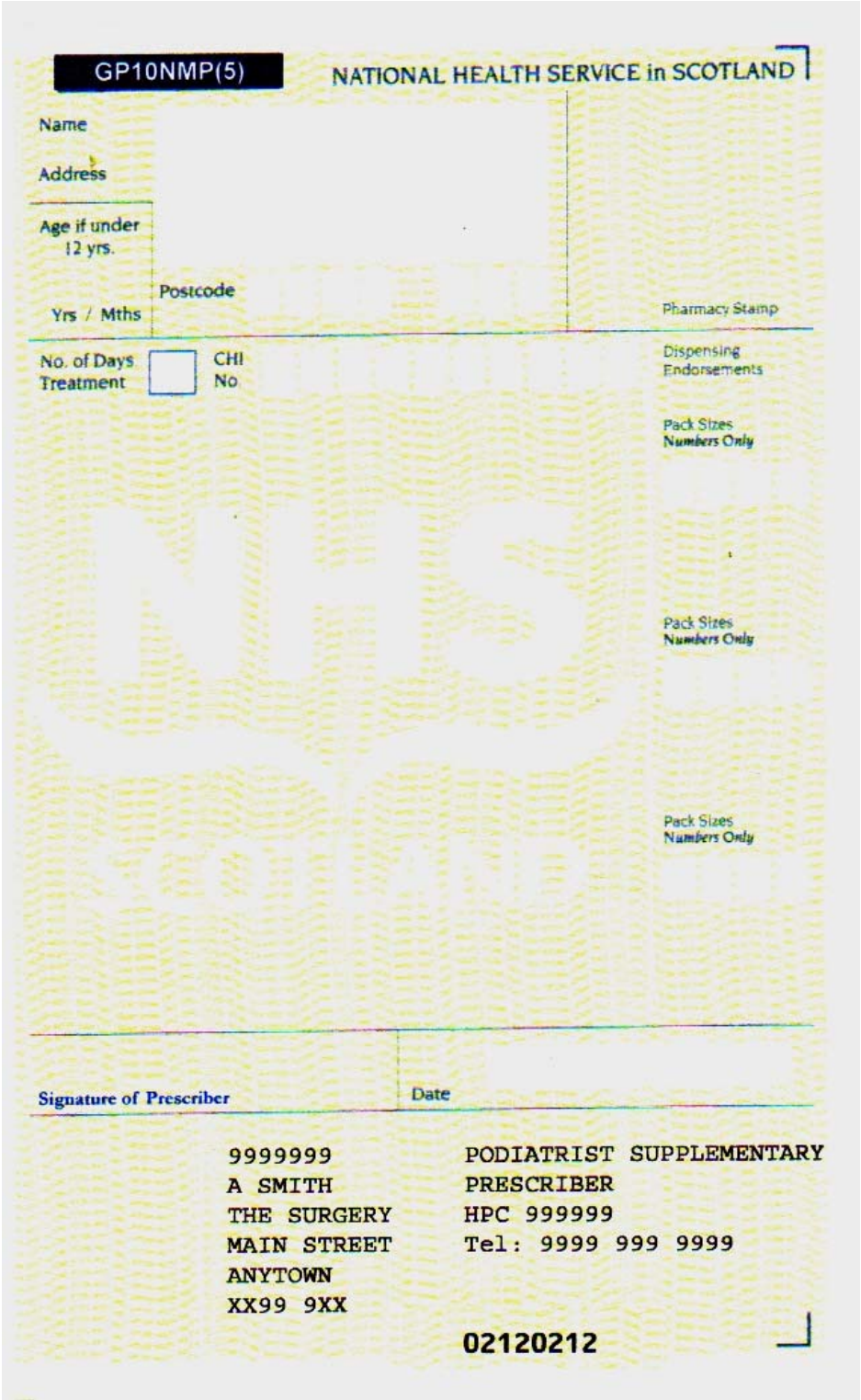
From:

Address for delivery of pads: (NHS organisation stores or pharmacy department/ or direct to the prescriber's address where agreed by NHS employer)**:**

……
……..
……
Post **Code:** ……..

Signed: ……Authorised Signatory) **Date:** ……
Print Name: …… **Telephone Number:**……

Sample GP10(NMP) Form



GP10NMP(5)

NATIONAL HEALTH SERVICE in SCOTLAND

Name

Address

Age if under 12 yrs.

Yrs / Mths

Postcode

Pharmacy Stamp

No. of Days Treatment

CHI No

Dispensing Endorsements

Pack Sizes *Numbers Only*

Pack Sizes *Numbers Only*

Pack Sizes *Numbers Only*

Signature of Prescriber

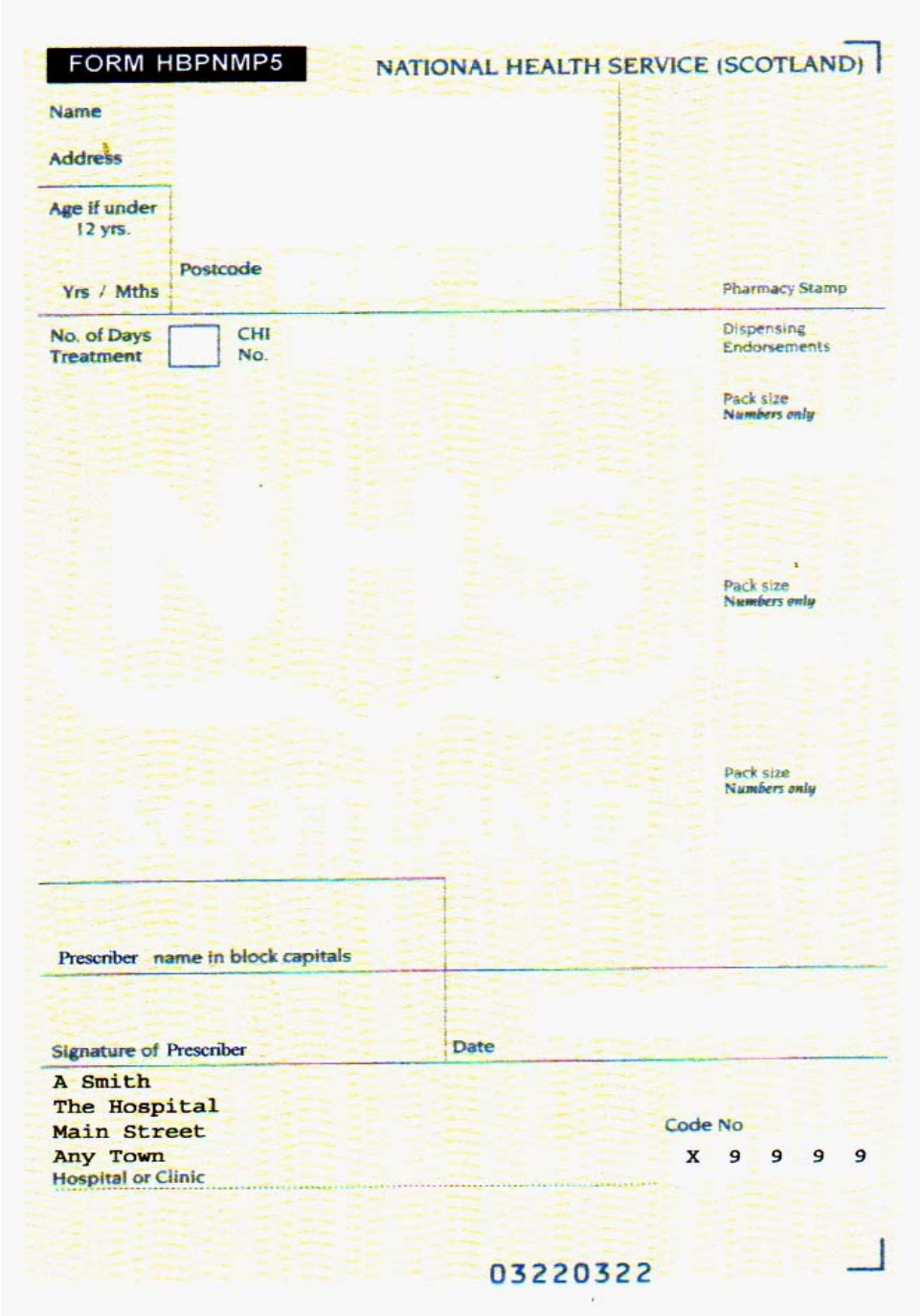
Date

9999999
A SMITH
THE SURGERY
MAIN STREET
ANYTOWN
XX99 9XX

PODIATRIST SUPPLEMENTARY PRESCRIBER
HPC 999999
Tel: 9999 999 9999

02120212

Sample HBP(NMP) Form



FORM HBPNMP5

NATIONAL HEALTH SERVICE (SCOTLAND)

Name

Address

Age if under 12 yrs.

Yrs / Mths

Postcode

Pharmacy Stamp

No. of Days Treatment

CHI No.

Dispensing Endorsements

Pack size *Numbers only*

Pack size *Numbers only*

Pack size *Numbers only*

Prescriber name in block capitals

Signature of Prescriber

Date

A Smith
The Hospital
Main Street
Any Town
Hospital or Clinic

Code No X 9 9 9 9

03220322

Annex D

How to complete the prescription form

1. Detailed advice on writing prescriptions is contained in the BNF

2. Information on the front of the prescription form should be written clearly and legible using indelible ink (preferably black) or by printing using appropriate computer prescribing stationery and a computer prescribing system.

3. The information required is as follows:

- The patient's title, forename, surname and address (including postcode) and if available the patient's Community Health Index (CHI) number.

- The patient's date of birth, and age if under 12 years.
  NB it is a legal requirement to write the patient's age on the prescription when prescribing Prescription Only Medicines for a child under 12 years of age.

- If using computer prescribing systems the above information must be printed; for had written prescription, enter if known e.g. from patient notes.

- For prescribing in primary care, and for patients whose prescriptions will be dispensed in the community, the prescription must contain the name of the prescribed item, formulation, strength (if appropriate) dosage and frequency, and quantity to be dispensed. The quantity prescribed should be appropriate to the patent's treatment needs, bearing in mind the need to avoid waste. Some medicines are only available in patient packs (or multiples thereof) and special containers and the pack (or multiple pack) quantity should be prescribed, provide this is clinically and economically appropriate. The quantity should be prescribed for solid preparations as number of dose units (number of tablets, capsules, lo, 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 of treatment can be given in place of quantity to be dispensed.

- In hospitals, prescriptions for inpatients should contain the name of the prescribed item, formulation, strength (in 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 care, whilst recognising local policies for example on the length of treatment provided for outpatients and the patients who are being discharged.

- The names of medicines should be written clearly. Prescribers are recommended to prescribe generically, except when to do so would not be

clinically appropriate or where there is no approved generic name – see BNF and the Scottish Drug Tariff. Names of medicines and generic titles should not be abbreviated. Exceptions to this rule are for the prescribing of some dressings and appliances, and of the compound or modified release medicines that have no approved non-proprietary name.

- Directions 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).

- Then prescriber must sign and date the form.

- **On hospital prescriptions only:** the AHPs name printed or hand written in the box provided, i.e. a contact name for the dispensing pharmacist.