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THE SOCIETY & COLLEGE OF RADIOGRAPHERS

Improving Patients' Access to Medicines:

A Guide to Implementing Diagnostic Radiographer Prescribing within the NHS in England

June 2017

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Document Control

This document has been adapted with permission for the Allied Health Professions Medicines Project by the Society and College of Radiographers and is based on the original document published by the Department of Health in 2006 which supports Nurse and Pharmacist independent prescribing. References to versions and authors from here on should be viewed in consideration of the original document.

Version Control	Comments	Authors
Development of draft versions	Initial development of adapted version of 2006 document to be specific and relevant to radiographic profession	Dianne Hogg Shelagh Morris Sue Johnson Charlotte Beardmore
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Introduction

This guide sets out the administrative and procedural steps needed to enable advanced practice diagnostic radiographers in England to act as independent and supplementary prescribers. It provides information and advice on good practice in the implementation of diagnostic radiographer independent and supplementary prescribing. It is adapted from the Department of Health guidance 2006[1] to reflect current best practice by other professions in implementing prescribing[2]

Scope of this guidance and effect of devolution

1. This guide sets out the steps to implement independent prescribing in the UK. Medicines legislation permits the introduction of independent prescribing for diagnostic radiographers 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.
2. This guide has been produced to help promote safe and effective prescribing by diagnostic radiographer prescribers and is applicable to the NHS, the independent and voluntary sectors.
3. NHS England is tasked with creating the NHS of the future that will work collaboratively across all sectors, with social care and commissioners and with patients and carers. The Government's mandate for NHS England[3] and the Next Steps[4] expect 7-day availability of services, movement of some services from secondary to primary care, reduction of patients being admitted to hospital when it is not the best place for their treatment, improvements in the care of patients with mental health problems and provision of seamless, 'joined up' care close to patients homes- which may be care homes. New care models are required to deliver many of these improvements which include an increase in the number of health professionals who can prescribe, supply or administer medicines to patients.

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[1] Department of Health (2006) Improving Patients' Access to Medicines: A Guide to Implementing Nurse and Pharmacist Independent Prescribing within the NHS in England http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4133747.pdf

[2] Whenever prescribing is referred to in this document, this refers to independent and supplementary prescribing

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/601188/NHS_Mandate_2017-18_A.pdf

[4] https://www.england.nhs.uk/publication/next-steps-on-the-nhs-year-forward-view

4. A recurring theme in the Five Year Forward View is faster and improved diagnostics.[5] Examples of 'one stop multidisciplinary clinics' and improved team working across the diagnostic imaging workforce demonstrate where major impact can be made on waiting times and access to timely diagnosis[6].
5. The guidance is applicable to diagnostic radiographer prescribing in all settings; where there are setting-specific requirements or information this is indicated in the document.
6. In the context of prescribing, diagnostic radiographers must be working in advanced clinical practice roles to be eligible to train to become prescribers. In this document, where reference is made to diagnostic radiographer prescribers this refers only to advanced diagnostic radiographer practitioners (ADRPs).
7. The content of this document is current at the time of publication. It is expected that employers, managers and individual diagnostic radiographer prescribers check recent guidelines and legislation to ensure up to date practice.
8. Where a radiographer is employed by more than one organisation, the prescribing role and attendant governance must be derived from each employer individually, rather than used interchangeably from a single employer (unless a previously agreed and governed arrangement exists). It is hoped that organisations will come together to ensure that their governance arrangements are in alignment.

Diagnostic radiographer prescribing

Definitions of independent and supplementary prescribing

9. Independent prescribing is defined as prescribing by an appropriate practitioner (doctor, dentist, nurse, pharmacist, paramedic, physiotherapist, podiatrist, optometrist, therapeutic and diagnostic radiographer) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing medicines. Within medicines legislation the term used is 'appropriate practitioner'.
10. In partnership with the patient, independent prescribing is one element of the clinical management of a patient. It requires an initial patient assessment, interpretation of that assessment, a decision on safe and appropriate use of medicines, and a process for ongoing monitoring. Normally prescribing would be carried out in the

[5] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[6] https://reader.exacteditions.com/issues/45247/page/4

context of practice within a multidisciplinary healthcare team, either in a hospital, a community setting or other healthcare provider setting, and within a single, accessible healthcare record.

11. Supplementary prescribers (diagnostic and therapeutic radiographers, nurses, pharmacists, paramedics, dietitians, physiotherapists, podiatrists and optometrists) can prescribe in partnership with a doctor (or dentist). Supplementary prescribers are able to prescribe any medicine, including controlled drugs and unlicensed medicines that are listed in an agreed clinical management plan. All supplementary prescribers may prescribe for any medical condition, provided that they do so under the terms of a patient-specific clinical management plan (CMP) agreed with a doctor. The CMP will be drawn up, with the patient's agreement, following diagnosis of the patient. Supplementary prescribing may still be the most appropriate mechanism for prescribing, for instance where an independent prescriber is newly qualified as a prescriber or where a team approach to prescribing is clearly appropriate, or where a patient's CMP includes certain medicines which the prescriber cannot prescribe independently (for example controlled drugs).
12. Non-medical health professionals who are legally able to train to become independent prescribers will qualify as supplementary prescribers also and their professional registration will be annotated as such.

Legal basis of independent prescribing by diagnostic radiographers

13. The initial legal basis for the introduction of nurse prescribing was provided by the following regulations:
    - The Medicinal Products: Prescription by Nurses, etc. Act 1992 [which amended the National Health Service Act 1977 (section 41) and the Medicines Act 1968 (section 58)];
    - The Medicinal Products: Prescription by Nurses, etc Act 1992: (Commencement No 1) Order 1994.

14. Subsequently Section 63 of the Health and Social Care Act 2001 enabled the Government to extend prescribing responsibilities to other health professions, including pharmacists. It also enabled the introduction of new types of prescriber, including the concept of a supplementary prescriber.
15. The Medicines and Human Use (Prescribing) (Miscellaneous Amendments) Order of May 2006 and associated medicines regulations, and subsequently the Human

Medicines Regulations 2012 and associated amendments enable specific non-medical health professions to undertake independent prescribing responsibilities.

Aims of independent prescribing

16. It is government policy to extend prescribing responsibilities to non-medical professions to:-
    - improve patient care without compromising patient safety;
    - make it easier for patients to get the medicines they need;
    - increase patient choice in accessing medicines;
    - make better use of the skills of health professionals;
    - contribute to the introduction of more flexible team working across the NHS.
    - enable patients to be seen and treated in the most appropriate setting by an appropriately skilled health professional.

17. Organisations should develop their strategic plan for the use of non-medical prescribing to include prescribing by advanced diagnostic radiographer practitioners (ADRPs). Typically this would involve senior managers and clinicians (doctors, diagnostic radiographers, pharmacists) and the drugs and therapeutics committee (or equivalent medicines governance and optimisation committee). The plan should be approved at Board level and would, for example:
    - recognise the benefits to patients of non-medical prescribing;
    - identify an initial range of clinical areas where patients could benefit;
    - identify a way to support and sustain the transition of staff to prescribing roles and the services they currently provide;
    - develop a communications plan aimed at informing both patients and all clinical and managerial staff;
    - include timescales for implementation;
    - identify a lead director to be responsible for implementation.

NHS care settings in which diagnostic radiographer prescribing could apply

18. ADRPs work in multidisciplinary teams in a range of clinical settings including:

- Traditional secondary care hospital-based radiology services providing a range of diagnostic examinations including the administration of contrast agents and adjunct medicines
- emergency and urgent care departments (acute hospitals and community facilities) assessing patients, producing images, reporting on the images and discharging patients.
- musculo-skeletal (MSK) ultrasound services including therapeutic injections
- bone health imaging and associated services.
- breast cancer services undertaking biopsies as part of their wider role.
- settings which are closer to patients' homes outside the traditional hospital settings. E.g. community hospitals or mobile facilities

19.. Diagnostic radiographer prescribers must adhere to the clinical governance arrangements already put in place by the organisation for these professionals as described in this document.

Implementation strategy

Which diagnostic radiographers can act as prescribers?

20. To undertake prescribing, the diagnostic radiographer must be working in an advanced practice role as defined by Health Education England[7] in collaboration with its multi-disciplinary partners including the allied healthcare professionals' professional bodies. Advanced practice is defined as;

    Advanced Clinical Practice is delivered by experienced registered healthcare practitioners. It is a level of practice characterised by a high level of autonomy and complex decision-making. This is underpinned by a masters level award or equivalent that encompasses the four pillars of clinical practice, management and leadership, education and research, with demonstration of core and area specific clinical competence.

21. *Advanced Clinical Practice embodies the ability to manage complete clinical care in partnership with patients/carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance patient experience and improve outcomes.*

[7] https://hee.nhs.uk/our-work/developing-our-workforce/advanced-clinical-practice/advanced-clinical-practice-definition

22. A diagnostic radiographer prescriber must have their name held on the Health and Care Professions Council (HCPC) professional register, with an annotation signifying that the diagnostic radiographer has successfully completed an approved programme of preparation and training for diagnostic radiographer prescribing and is qualified as an independent and supplementary prescriber.

Selection of diagnostic radiographers to train to become prescribers

23. The selection of diagnostic radiographers who will be trained as prescribers is a matter for employing organisations who are best placed to assess local service and patient needs. All individuals selected for prescribing training must have the opportunity to prescribe in the post that they will occupy on completion of training. The clinical area(s) in which they will prescribe should also have been identified before they begin training to prescribe. This will almost certainly be in the field in which they already hold considerable expertise. See annex J for selection criteria.
24. The entry requirements for HCPC registrants are listed in the following table (Outline Curriculum Framework 2017):

a) Be registered with the HCPC in one of the relevant Allied Health Professions.

AND

b) Be professionally practising in an environment where there is an identified need for the individual to regularly use independent prescribing (diagnostic radiographers)

AND

c) Be able to demonstrate support from their employer/sponsor including confirmation that the entrant will have appropriate supervised practice in the clinical area in which they are expected to prescribe.

AND

d) Be able to demonstrate medicines and clinical governance arrangements are in place to support safe and effective supplementary and/or independent prescribing

AND

e) Have an approved medical practitioner, normally recognised by the employer/commissioning organisation as having:

I) experience in the relevant field of practice,
II) training and experience in the supervision, support and assessment of trainees and
III) has agreed to;
- Provide the student with opportunities to develop competences in prescribing

- Supervise, support and assess the student during their clinical placement.

AND

f) Have normally at least 3 years relevant post-qualification experience in the clinical area in which they will be prescribing.

AND

g) Be working at an advanced practitioner or equivalent level.

AND

h) Be able to demonstrate how they reflect on their own performance and take responsibility for their own Continuing Professional Development (CPD) including development of networks for support, reflection and learning.

AND

i) In England and Wales, provide evidence of a Disclosure and Barring Service (DBS) or AccessNI check within the last three years or, in Scotland, be a current member of the Protection of Vulnerable Groups (PVG) scheme.

*If self-employed, must be able to demonstrate an identified need for prescribing and that all appropriate governance arrangements are in place

25. The three key principles that should be used to prioritise potential applicants are:
    - to maximise patient safety;
    - maximum benefit to patients and the NHS in terms of quicker and more efficient access to medicines for patients to support medicines optimisation/streamlining clinical pathways;
    - better use of the professional's skills to support service transformation.

    The individual practitioners must also understand and accept the higher level of clinical responsibility associated with prescribing.

26. Health Education England should liaise with NHS employers and Higher Education Institutions, to ensure that applicants and the number of course places can be appropriately matched. NHS organisations may find it helpful to work together locally to agree priorities for access to prescribing courses in alignment with local priorities and in collaboration with Local Workforce Advisory Boards and Sustainability and Transformation Partnerships.

Commissioning services

27. Diagnostic radiographer prescribers will give providers of care and all who commission services the opportunity to change the way they provide services to patients. A wider range of professionals who can act as prescribers provides a range

of skills and expertise from which to draw to meet patient needs. Using diagnostic radiographer prescribers can, amongst other things, help to:

- fill geographical or skills gaps in services;
- meet diagnostic imaging targets for early cancer diagnosis
- manage certain long term conditions such as musculo-skeletal disorders
- minimise delays to treatment

Funding for diagnostic radiographer prescribing training courses

28. In some regions, funding for education programmes is now devolved to NHS organisations, in others the funding is managed by Health Education England. It is for NHS organisations to decide how this funding is best used to meet the needs of their client group.

Non-NHS staff

29. ADRPs employed by non-NHS organisations, and who are commissioned to provide the majority of their clinical services to NHS patients (e.g. Mobile MRI or CT service providers) may have their training funded and should be considered by CCGs.

Conflicts of interest

30. In nominating for training any diagnostic radiographers whose posts are directly or indirectly funded by pharmaceutical and other companies, employers should be aware of, and take necessary steps to resolve, any conflicts of interests that may subsequently arise in the diagnostic radiographer's practice.
31. *The Practice Guidance for Radiographers independent and/or supplementary prescribers* (Society and College of Radiographers, 2016)[8] states the requirements of the diagnostic radiographer prescriber where there are conflicts of interest.
32. HCPC registrants should make patients aware of that interest and must ensure independence from influence when prescribing and maintain a register of interests which may be produced on request. The register may be kept by the individual or completed through organisational corporate governance mechanisms.
33. NHS bodies should bear in mind issues of potential conflict of interest when they are considering commercial sponsorship of events aimed at prescribers.

[8] http://www.sor.org/learning/document-library/practice-guidance-radiographer-independent-andor-supplementary-prescribers

Funding from other sources

34. If it so wishes, an NHS organisation or a private organisation may also pay for the training of diagnostic radiographers through other sources of funding. Individual diagnostic radiographers may choose to fund themselves; this is an arrangement with the university of their choice but they must still meet all the entry requirements for the course (annex J). Caution should be taken to avoid a conflict of interest.

Training and preparation for independent prescribing

Training programmes for independent prescribing

35. The Health and Care Professions Council (HCPC) have set out standards in respect of prescribing training for diagnostic radiographers, and will only validate new recordable courses against these (see HCPC website). The *Outline Curriculum Framework* (OCF), hosted by the Allied Health Professions Federation defines the entry criteria and specific curriculum for all allied health professionals legally able to prescribe. Only successful completion of programmes approved by the HCPC will lead to registration as a diagnostic radiographer prescriber. The programme must have been approved for diagnostic radiographers before a member of that profession may enter the programme. It is important to note that not all programmes offer access to all the prescribing professions. The HCPC offers information about the programmes they have approved on their website with contact details for the relevant university for more specific information.
36. Health Education England has some level of influence over the detail of the curriculum for prescribing training (as commissioner of the course). It is expected that course commissioners and validators approve only those courses that demonstrate content that is consistent with published guidance and that the learning outcomes of the curricula are to be achieved.
37. Approved education programmes leading to annotation on the relevant professional register as an independent and supplementary prescriber must be a specific programme of preparation at a minimum of degree level (level six). The programme comprises a minimum of 26 days at a Higher Education Institution (HEI) plus 12 days 'learning in practice', during which a supervising designated 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 approximately 6 months. The student will also need to undertake an element of self-directed learning. For distance learning programmes, there must be a minimum of 8 face-to-face taught days (excluding assessment) plus 10 ten days protected learning time. In exceptional circumstances where this is not practically possible, video-conferencing in which interaction between all participants is possible will be acceptable. Attendees on the multidisciplinary training programmes will be already expert practitioners working at advanced clinical practice level and meeting the entry requirements as detailed in paragraph 24.

38. The training programmes include an assessment of theory and practice that must be passed before the practitioner's entry on the HCPC register is annotated, to indicate that he/she holds a qualification for prescribing.
39. Individual higher education institutions, where appropriate, may use approved prior learning (APL) or exemptions, to give credit for previous learning.
40. In addition to the time spent on the formal programme, it is important that employers of diagnostic radiographers undertaking the programme should recognise the demands of private study and provide support where necessary. Employers may also consider providing mentoring opportunities for these diagnostic radiographers (see below).

Supervising/Designated Medical Practitioner (DMP)

41. The period of learning in practice will be directed by a DMP, who will also be responsible for assessing whether the learning outcomes have been met and whether the trainee has acquired certain competencies. Normally, these outcomes and competencies will be identified by the HEI running individual courses.
42. The Designated Medical Practitioner (DMP) has a critical and highly responsible role in educating and assessing the non-medical prescriber and assuring competence in prescribing.
43. Before taking on the role of DMP, the doctor and the HEI should consider the implications of undertaking this role safely and effectively. It is then important that the DMP and the HEI running the prescribing programme should work closely together.
44. *'Training non-medical prescribers in practice – A guide to help doctors prepare for and carry out the role of designated medical practitioner'* published by the National

Prescribing Centre in 2005[9] should help to inform the selection of Designated Medical Practitioners.

45. Training new prescribers will undoubtedly take up some time. The approach to teaching and learning should be developed on an individual basis, so it is difficult to predict how much time this will involve.

'Buddying' schemes during training

46. It is unlikely that a trainee will need to spend all of the period of learning in practice with their designated medical practitioner (DMP), as other clinicians may be better placed to provide some of the learning opportunities. However, the DMP remains responsible for assessing whether all of the learning outcomes have been met. Some form of 'buddying' link may also be valuable, for instance, with a current diagnostic radiographer, nurse or pharmacist prescriber, or with a senior and experienced pharmacist.

Continuing Professional Development

47. All diagnostic radiographers have a professional responsibility to keep themselves abreast of clinical and professional developments. This is no less true for prescribing. Diagnostic radiographer prescribers will be expected to keep up to date with evidence and best practice in the management of the conditions for which they prescribe, and in the use of the relevant medicines. The HCPC standards of continuing professional development expect that all registrants undertake CPD related to their practice; prescribers must include their prescribing practice in this activity.[10]

48. Diagnostic radiographers may use the learning from this activity as part of their CPD activity. The employer should ensure that the practitioner has access to relevant education and training provision. It is good practice for employers to support diagnostic radiographer prescribers in pursuing self-directed study. Details of additional training and updating will need to be incorporated by the diagnostic radiographer into their personal professional profile, in order to meet biannual reregistration requirements set by the HCPC.

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[9] http://www.webarchive.org.uk/wayback/archive/20140627112130/http://www.npc.nhs.uk/non_medical/resources/designated_medical_practitioners_guide.pdf

[10] http://hpc-uk.org/assets/documents/10003B70Yourguidetoourstandardsofcontinuingprofessionaldevelopment.pdf

49. In addition, the document *"a competency framework for all prescribers*" published by the Royal Pharmaceutical Society[11] will help diagnostic radiographer prescribers to structure CPD activities by comparing their knowledge and competence against a set of competencies expected of an exemplar prescriber.

'Buddying'/mentor post - qualification

50. Support from other professional colleagues is invaluable to non-medical prescribers, especially to those who are newly qualified. Many non-medical prescribers already have a buddy/mentor after qualifying to prescribe. This could be a doctor, diagnostic radiographer, nurse or pharmacist and is a sensible way of enhancing continuing professional development.
51. Supplementary prescribing is also a useful mechanism to enable new non-medical prescribers to develop their expertise and confidence in prescribing.

Prescribing medicines under independent prescribing arrangements

52. Diagnostic radiographers who have successfully completed an independent prescribing course may prescribe any licensed medicine, (i.e. products with a valid marketing authorisation (licence) in the UK), and any licensed medicine used outside of the marketing authorisation (off-license / off-label), for any medical condition within their clinical competence, scope of practice and level of experience. Currently they are unable to prescribe any controlled drugs from schedules 1-5.

Prescribing within competence

53. All diagnostic radiographer prescribers must work within their own level of professional competence and expertise, and must seek advice and make appropriate referrals to other professionals with different expertise. Diagnostic radiographers are accountable for their own actions, and must be aware of the limits of their skills, knowledge and competence. Diagnostic radiographer prescribers must act within the HCPC standards of professional conduct, performance and ethics[12], and the HCPC standards for prescribing[13].

[11] https://www.rpharms.com/resources/frameworks/prescribers-competency-framework

[12] http://www.hpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics

[13] http://www.hpc-uk.org/aboutregistration/standards/standardsforprescribing/

Prescribing licensed medicines for unlicensed uses ('off-label' or 'off-licence')

54. Diagnostic radiographer prescribers may prescribe medicines independently for uses outside their licensed indications / UK marketing authorisation (known as 'off-licence' or 'off-label'). They must however, accept professional, clinical and legal responsibility for that prescribing, and should only prescribe 'off-label' where it is accepted clinical practice. A local policy for the use of medicines 'off-label' should be approved through mechanisms such as drug and therapeutic committees or the equivalent. The prescriber should explain the situation to the patient/guardian where possible, but where a patient is unable to agree to such treatment, the prescriber should act in accordance with best practice in the given situation and within the policy of the employing organisation.

Unlicensed medicines (products without a UK marketing authorisation)

55. Diagnostic radiographer independent prescribers are not permitted to prescribe unlicensed medicines. If the diagnostic radiographer prescriber uses supplementary prescribing and there is a clinical management plan (CMP) in place which includes the medicine and the diagnostic radiographer, then unlicensed medicines can be prescribed.

Borderline Substances

56. All NHS prescribers will need to abide by any NHS terms of service under which they operate. For example, borderline substances may be prescribed but the prescription will need to be marked 'ACBS'. A list of Advisory Committee of Borderline Substances (ACBS) approved products and the circumstances under which they can be prescribed, can be found in part XV of the Drug Tariff. Although this is a non-mandatory list, diagnostic radiographer independent prescribers should normally restrict their prescribing of borderline substances to items on the ACBS approved list. They should also work within the guidance of their employing organisation.

Appliances / Dressings in Part IX of the Drug Tariff

57. Diagnostic radiographer independent prescribers may also prescribe any appliances or dressings that are listed in Part IX of the Drug Tariff. Diagnostic radiographers prescribing in secondary care are not restricted to prescribing appliances/dressings

from part IX of the Drug Tariff, but should take into account local formulary policies and the implications for primary care.

Clinical governance in prescribing

58. Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.
59. Chief executives are legally accountable for the quality of care that patients receive and for securing patient safety.
60. The employing organisation must ensure that diagnostic radiographer prescribing is included within their overall clinical governance framework, to ensure that diagnostic radiographers practice safely and competently. An example clinical governance framework for diagnostic radiographer independent prescribing can be found in annex D. It must include systems for:
    - selection – all entrants to prescribing training must be selected according to criteria indicating their potential to prescribe safely in the area in which they will practice. This will usually include evidence that they have appropriate specialist knowledge and an opportunity to prescribe within their work
    - completion of accredited education programmes – the HCPC provides and assesses the standards for training and education programmes. Employers also have a duty to ensure that those training to prescribe are supported through their training programme
    - ensuring that the names of prescribers are annotated on their professional register, before they begin to prescribe. This should be ascertained via the usual register checking arrangements that are undertaken for new employees
    - ensuring arrangements are in place for assessment of practice, clinical supervision, audit, and continuing professional development for all diagnostic radiographer prescribers
    - developing a risk management plan – this will ensure that potential risks associated with extending clinical practice are recognised and minimised
    - ensuring that the parameters of an individual's prescribing are agreed between the prescriber, their manager or local professional lead (e.g. the non-medical

prescribing lead), and their employer. This is best carried out using a personal formulary approach which is a continuation from that developed during the course of study. The formulary should include the context in which the non-medical prescriber will prescribe the medicine and how the knowledge and competence to prescribe the medicine was achieved and is being maintained / developed.

- ensuring that drug and therapeutic committees (or equivalent) are aware of the medicines being prescribed by diagnostic radiographer prescribers

61. Diagnostic radiographers should use clinical supervision arrangements or equivalent 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.

62. Peer review, support and mentoring arrangements should be established for diagnostic radiographers. Audits, clinical governance arrangements and their CPD requirements will allow diagnostic radiographers to reflect on their prescribing practice. The Society and College of Radiographers has developed a clinical governance framework[14] both for radiographer 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 prescriber's responsibility to engage in clinical governance activities and complements the example framework in annex E.

63. A review of prescribing by diagnostic radiographers 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 audit of practice and interrogation of local data collection systems, and where relevant, prescription and cost data (ePACT) available from the Business Services Authority (if using FP10 prescriptions) and from hospital internal systems.

64. Good practice examples of non-medical prescribing clinical governance frameworks can be found at Annex E.

[14] Practice Guidance for Radiographers independent and/or supplementary prescribers http://www.sor.org/learning/document-library/practice-guidance-radiographer-independent-andor-supplementary-prescribers

Independent/Private sector

65. Diagnostic radiographer prescribers who work in non-NHS settings where clinical governance systems may be different or may not be applied in the same way, must ensure they comply with requirements to demonstrate their competence to practice. For example, they must be able to show how they audit their practice, keep up-to-date with current guidance, and how they safeguard the patients in their care.

Good practice, ethics and issues for all prescribers

Responsibility for prescribing decisions

66. A diagnostic radiographer prescriber can only order a medicine for a patient whom they have assessed for care. Accountability for the prescription rests with the non-medical prescriber who has prescribed or ordered the medicines.

Informing patients

67. Diagnostic radiographer prescribers must ensure that patients are aware that their care is being managed by a non-medical practitioner and of the scope and limits of their prescribing. So there may be circumstances where the patient has to be referred on to another healthcare professional, to access other aspects of their care.

Prescribing for self, family and friends

68. Diagnostic radiographer prescribers must not prescribe any medicine for themselves. Neither should they prescribe a medicine for anyone with whom they have a close personal or emotional relationship, other than in an exceptional circumstance.[15]

Gifts and benefits

69. The advertising and promotion of medicines is strictly regulated under the Medicines (Advertising) Regulations 1994, and it is important that diagnostic radiographer prescribers, and indeed all health professionals, make their choice of medicinal product for their patients on the basis of evidence, clinical suitability and cost effectiveness alone.[16]

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[15] HCPC standards of professional conduct, performance and ethics http://www.hpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics

[16] Practice Guidance for Radiographers independent and/or supplementary prescribers http://www.sor.org/learning/document-library/practice-guidance-radiographer-independent-andor-supplementary-prescribers

70. As part of the promotion of a medicine or medicines, suppliers may provide inexpensive gifts and benefits, for example pens, diaries or mouse mats. Personal gifts that are given to influence your prescribing activity are prohibited and it is specified in law that a prescriber must not solicit or accept a gift, pecuniary advantage, benefit or hospitality that is prohibited by regulation[17].

71. Companies may also offer hospitality at a professional or scientific meeting or at meetings held to promote medicines, but such hospitality should be reasonable in level and subordinate to the main purpose of the meeting. Employers should have local policies for working with the pharmaceutical industry which cover gifts and benefits, as well as, for example, access to prescribers and sponsorship. Prescribers should familiarise themselves with these policies and are expected to abide by them.
72. The Medicines and Healthcare products Regulatory Agency (MHRA) is responsible for enforcing the legislation on advertising and promotion of medicines. Any complaints about promotional practices should be referred to the MHRA or to the industry's self-regulatory body, the Prescription Medicines Code of Practice Authority.

Patient records: Access and updating

73. 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 in a timely manner all professionals involved in a patient's treatment with the information needed for them to care safely and effectively for that patient. It is a necessary 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 pre-requisite for promoting safe and effective care for patients.
74. 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 failing that, as soon as possible after the consultation. **Only in very**

[17] Human Medicines Regulations 2012
http://www.legislation.gov.uk/uksi/2012/1916/part/14/chapter/2/crossheading/advertising-to-persons-qualified-to-prescribe-or-supply-etc/made

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 patient record and onto the diagnostic radiographer patient record (where a separate record exists).

75. It is recommended that the record indicates clearly:
    - The date of the prescription;
    - The name of the prescriber (and that they are acting as a diagnostic radiographer independent prescriber or a diagnostic radiographer supplementary prescriber);
    - The name of the item prescribed, together with the quantity (or dose, frequency and treatment duration where relevant).

76. To aid safe administration of medicines, 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 four hours by mouth as required for pain, maximum of 20mls in any 24 hours’ or ‘50 mls of Omnipaque 350, intravenous, by bolus injection’.
77. In the case of topical medicines the name of the prescribed item, the strength (if any), the quantity to be applied and the frequency of the 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 General Sales List and Pharmacy medicines provided ‘over the counter’ is also recorded.

Adverse Drug Reaction Reporting

MHRA Yellow Card Scheme

78. The Yellow Card Scheme is a voluntary scheme, through which healthcare professionals notify the Medicines and Healthcare products Regulatory Agency (MHRA) of suspected adverse drug reactions. The MHRA encourages 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 medicines, including herbal medicines. Serious reactions include those that are fatal, life threatening, disabling, incapacitating or which result in or prolong hospitalisation and/or are medically significant.

79. The 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.mhra.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). Patients, parents, carers etc can also report suspected adverse drug reactions using the above methods and there is also a freephone number - 0808 100 3352, that can be used.
80. The bulletin "Drug Safety Update", issued by the MHRA contains advice and information on drug safety issues. All prescribers are encouraged to routinely consult the bulletin and keep up-to-date with new information about safe use of medicines. Copies are also available from the MHRA[18].

Role of the National Reporting and Learning System

81. 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 diagnostic radiographer prescriber using both local and national reporting systems. The National Reporting and Learning System (NRLS), aims to improve the safety of NHS patient care, by promoting a culture of reporting and learning from adverse incidents across the NHS[19]. A reporting system, the NRLS has been developed to draw together information on adverse incidents. This will help the NHS to understand the underlying causes of patient safety problems, and to act to introduce practical changes to prevent mistakes.
82. All NHS organisations in England and Wales can now submit reports of patient safety incidents to the NRLS. These reports will enable NHS Improvement to build a clearer national picture of the problems affecting patient safety.

[18] https://www.gov.uk/government/publications/drug-safety-update-monthly-newsletter
[19] https://report.nrls.nhs.uk/nrlsreporting/

83. 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 NRLS
    - Reporting through the local healthcare organisation's established system.

84. NHS Improvement publishes statistics on trends and issues identified through the NRLS to promote a learning culture in the NHS. NS Improvement 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.

Legal and Clinical Liability

Liability of prescriber/Professional indemnity

85. Prescribers are accountable for all aspects of their prescribing decisions. They should therefore only prescribe those medicines they know are safe and effective for the patient and the condition being treated or investigated. They must be able to recognise and deal with pressures (e.g. from the pharmaceutical industry, patients or colleagues) that might result in inappropriate prescribing.
86. All prescribers should ensure that they have sufficient professional indemnity insurance, for instance by means of membership of a professional organisation or trade union which provides this cover.
87. The UK Government has introduced legislation[20] which requires HCPC registrants to have a professional indemnity arrangement in place as a condition of their registration with HCPC. The majority of diagnostic radiographer prescribers will already meet this requirement and will not need to take any further action. They will either work in an employed environment where their employer will indemnify them, and / or if they undertake self-employed work, they will have already made their own professional indemnity arrangements.
88. However, some registrants may need to take steps to make sure that they have a professional indemnity arrangement in place[21]. Many employers may expect individual health professionals to hold their own professional indemnity in addition to

[20] http://www.legislation.gov.uk/uksi/2014/1887/contents/made
[21] http://www.hcpc-uk.org/registrants/indemnity

any employer vicarious liability insurance that may be in place. Prescribers must be aware of the level of indemnity to determine whether it is sufficient for purpose.

89. Both the employer and employee (or contractor) should ensure that the employee's job description (or contractor's agreed arrangements) includes a clear statement that prescribing is required as part of the duties of that post or service.

Liability of employer

90. Where a diagnostic 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, diagnostic radiographer independent prescribers are individually professionally accountable to the HCPC for this aspect of their practice, as for any other, and must act at all times in accordance with the HCPC Standards of Conduct, Performance and Ethics[22].

Dispensing of prescribed items

Dispensing Doctors in primary care

91. Where a GP practice is a dispensing practice, prescriptions from radiographer prescribers can be dispensed by the practice but only for the dispensing patients of that practice. Dispensing doctors cannot dispense prescriptions written by diagnostic radiographer prescribers for patients of other practices.
92. Reimbursement for prescriptions written by diagnostic radiographer prescribers can be claimed by dispensing doctors; payment for the prescriptions submitted will be made to the senior partner.

Simultaneous prescribing and dispensing or prescribing and administration of a medicine

93. There should, other than in exceptional circumstances, be separation of prescribing and dispensing roles, in keeping with the principles of safety, clinical and corporate governance. Society and College of Radiographers' *Practice Guidance for Radiographers independent and/or supplementary prescribers*[23] states that diagnostic radiographers should ensure that there is separation of prescribing and

[22] http://hpc-uk.org/publications/standards/index.asp?id=38

[23] Practice Guidance for Radiographers independent and/or supplementary prescribers http://www.sor.org/learning/document-library/practice-guidance-radiographer-independent-andor-supplementary-prescribers

dispensing wherever possible. An example of this could be where the diagnostic radiographer prescribes a medicine that they then take from stock in an urgent care centre where an out of hours stock is stored in a locked cupboard. In exceptional circumstances, where a diagnostic radiographer is both prescribing and dispensing a patient's medication, a second suitably competent person should be involved in the checking process.

94. In such exceptional circumstances, prescribing and dispensing can be carried out by the same individual, provided that:
    - clear accountability arrangements are in place to ensure patient safety and probity, and;
    - there are audit and clinical governance arrangements in place, which can track prescribing and dispensing by diagnostic radiographer independent prescribers. Where the two roles do co-exist, another person must carry out a final accuracy check. Where possible, a check for clinical appropriateness should also be carried out.

95. A similar scenario would be simultaneous prescribing and administration which 'should be undertaken only in exceptional and rare circumstances and only if it is in the patient's best interests'. The diagnostic radiographer prescriber '…should ensure wherever possible that a second person checks that their prescription is what is administered to the patient. The second ''checker" need not be a prescriber or registered health-professional themselves but should be able to verify that the correct medicine is being supplied to the patient'.[24]

Verification of prescribing status

Role of the pharmacist on verification of prescribing status

96. The dispensing pharmacist will need to be sure that the prescriber has qualified as a diagnostic radiographer prescriber.
97. The prescription form will indicate whether a prescriber is a diagnostic radiographer prescriber. The dispensing pharmacist will, of course, need to use their professional

[24] [24] Practice Guidance for Radiographers independent and/or supplementary prescribers http://www.sor.org/learning/document-library/practice-guidance-radiographer-independent-andor-supplementary-prescribers

judgement, just as they do for any prescriptions, to assess whether a prescription is appropriate for a particular patient.

98. To enable pharmacists to check whether a prescription handed in for dispensing is bona fide, all NHS employers should keep a list of all diagnostic radiographer prescribers employed by them. It is also recommended that the employing authority (NHS or private) holds a copy of the prescriber's signature. Individuals should be prepared to provide specimen signatures to pharmacists, should that be required.

99. Most enquiries from dispensing pharmacists will be resolved by telephoning the prescriber, or the prescriber's employer. However, for general queries about the diagnostic radiographer's prescribing qualification (e.g. in the case of receiving a private prescription), the pharmacist can interrogate the professional register on the HCPC website http://www.hcpc-uk.org. Using the diagnostic radiographer prescriber's profession, surname and/or registration number will confirm if the diagnostic radiographer has live registration.

Role of the Prescription Pricing Division of the NHS Business Services Authority

100. In the case of FP10 prescriptions, the Prescription Pricing Division of the NHS Business Services Authority (NHSBSA) checks to ensure that the diagnostic radiographer prescriber who has written the prescription is listed as having permission to prescribe against that cost code, such as the GP practice, service or organisation.

Urgent dispensing in primary care

101. It is not anticipated that a diagnostic radiographer prescription would require dispensing out of normal pharmacy opening hours however if an exception should occur the following would apply. Many community pharmacies are open out-of-hours, the NHS Choices website contains a full list of community pharmacies including opening hours. Hospitals and Out-of-Hours Services will have local arrangements for supplying medicines out-of-hours, which should be brought to the attention of all prescribers.

Dispensing of items in Scotland, Wales and Northern Ireland

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

Dispensing items against diagnostic radiographer prescriber's prescriptions in hospital pharmacies

103. An up-to-date list of all qualified diagnostic radiographer independent prescribers employed by the hospital will need to be kept in the hospital pharmacy. Pharmacy staff should check the prescriber against the list. The same process will apply for in-patient, outpatient and discharge prescriptions. In general, prescriptions written on forms intended for dispensing in the community (FP10 forms) are not intended for dispensing by hospital pharmacies.

Independent prescribing monitoring information

Prescribers contracted to a GP practice

104. The NHS Business Services Authority (NHSBSA) reimburses costs to dispensing contractors and provides essential information electronically to authorised users. Prescribing by diagnostic radiographer prescribers on FP10 prescriptions will be identifiable in ePACT.net services and other NHSBSA Information Systems. NHS England Local Area Teams will be expected to provide routine data analysis of all prescribing which may include analysis of cost effectiveness and quality.

105. If a prescriber is prescribing on behalf of a GP practice, they can obtain prescribing data through electronic Prescribing and Financial Information for Practices (ePFIP) on the NHS Business Services Authority website: www.nhsbsa.nhs.uk. This provides detail for individual prescribers, down to presentation and prescription quantity level. The NHS Business Services Authority website provides information about ePFIP and how to access it.

Prescribers contracted to a hospital trust

106. Typically, the hospital pharmacy department will monitor prescribing and provide feedback on all prescribing in hospitals to both clinicians and managers. Many hospitals use electronic prescribing and administration systems which can generate

prescribing data. Diagnostic radiographer prescribers working in these settings should ask the non-medical prescribing lead for this information.

107. The route for accessing prescribing data for non-medical prescribers depends on where their prescribing costs are allocated. Diagnostic radiographer prescribers can expect to receive information via their non-medical prescribing lead to monitor their prescribing.

Annexes

Annex A: Notification of prescriber details to the Prescription Pricing Division of the NHS Business Services Authority for Prescribing in Primary Care

1. The details of diagnostic radiographer prescribers employed and practising in a primary care setting and intending to prescribe on personalised FP10 prescriptions must be registered with the NHS Business Services Authority (NHSBSA) before prescriptions for that prescriber can be ordered. Hospital-based prescribers should refer to Annex E. This must not be done until the diagnostic radiographer prescriber has passed all aspects of the prescribing course and has the qualification annotated on their professional register entry.
2. Notification of required details by the prescribers' employer or another authorised person to the NHSBSA enables the setting up of automatic monitoring processes, as well as allowing the provision of prescriber details to the supplier for the printing of prescription pads.
3. The current form as displayed on the NHSBSA websitewww.nhsbsa.nhs.uk must be used for notification. Additional forms from the website must be used to notify the NHSBSA of changes in circumstances (e.g. name) as they occur. The forms contain instructions for completion and the email address to which the completed form must be sent.

Changes to prescriber details

4. It is the responsibility of employers of diagnostic radiographer prescribers who are registered with the NHSBSA and who are working in primary care settings, to ensure that changes to the prescriber's details are notified to NHSBSA 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.

Prescriber ceases employment / prescribing.

5. The employer, must inform the NHSBSA 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 must do this by submitting the relevant NHSBSA form as described above. This includes circumstances where the employer is contracted to provide services for other commissioning organisations.

6. Employers must annotate their lists of diagnostic radiographer prescribers with the reasons for any changes, to ensure that an up-to-date record exists.

Annex B – Prescription Forms- completion

- All prescription forms require information to be entered on them (by printing or writing or a 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, as well as to the correct prescribing budget.

Prescribing in Primary Care settings

Ordering prescription forms

- Employers should note that prescription forms are not issued automatically; authorised persons must order FP10 prescriptions from the supplier. Prescriptions should also be re-ordered as and when required.
- Orders for a new prescriber's prescription forms should not be placed earlier than 42 days prior to the date the individual is scheduled to begin prescribing for the organisation, as the supplier cannot access NHSBSA data before this point.
- Allow at least 4 working days between notifying changes to the NHSBSA and ordering prescriptions. This will allow time for data input and transmission of updated data files to the supplier. Orders are currently placed online and require the prescriber's correct details to have been uploaded from the NHSBSA prior to ordering.
- Prescriptions are normally sent to the address of the person who orders them (an alternative address can be specified 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 to the current supplier.

Prescription forms FP10P pre-printing specification.

- The top of the prescribing area will be overprinted to identify the type of prescriber i.e. DIAGNOSTIC RADIOGRAPHER PRESCRIBER
- The address box will be overprinted to identify:
  - the diagnostic radiographer prescriber's name and registration number
  - the name, address and phone number of the employing organisation
  - the name and code of the organisation they are prescribing on behalf of
  - the practice code

- Information about prescription overprinting and single sheet versions of the FP10P is available on the NHSBSA web page at www.nhsbsa.nhs.uk
- Any prescriber who works for more than one employer or in more than one setting for example they prescribe on behalf of two CCGs **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 diagnostic radiographer prescribers

- Diagnostic radiographer prescribers prescribing for hospital inpatients or outpatients may use the following methods to prescribe:
    - Hospital in-patient prescription form or sheet to be used for inpatients and discharge supplies only. A prescription charge is not levied for inpatients.
    - Internal hospital prescription form – to be used for outpatients 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 (please note: internal hospital forms cannot be accepted for dispensing by community pharmacies).
    - Electronic prescription and administration systems- many hospitals are implementing these systems across all services provided by the organisation where medicines are prescribed and administered. Local support and implementation teams will enable the diagnostic radiographer prescriber to be registered with the system and enabled to prescribe.
    - FP10 prescription forms, where the medicine will be prescribed by a hospital prescriber and dispensed in a community pharmacy. These are mainly used in circumstances where the service is delivered away from the hospital site and therefore the pharmacy (please note: the prescriber's employer should establish a local policy on the use of prescription forms in these circumstances.). These prescriptions are printed with previously agreed service-specific prescribing account details, not individual prescriber details. Prescribing (EPACT) data is available from the NHSBSA but is displayed at service level only. There is currently no requirement to notify the NHSBSA of details of hospital-based diagnostic radiographer independent prescribers, or changes to their details. If

diagnostic radiographer prescribers need to use these prescriptions, they must write their prescribing designation on each prescription as:
DIAGNOSTIC RADIOGRAPHER PRESCRIBER, and the prescriber's HCPC registration number:

Non-NHS Employees

12. A non-NHS diagnostic radiographer 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 is commissioned to provide an NHS service and has an arrangement which allows the non-NHS organisation to use NHS community pharmacy dispensing services. The NHS commissioner 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 a prescription form

13. Detailed, up to date advice on prescription writing is contained in the British National Formulary (BNF).
14. 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 as follows:
    - the patient's title, forename, surname and address (including postcode) and if available the patient's NHS number
    - patient's age and date of birth (must be printed by computer prescribing systems; for hand written prescriptions - enter if known e.g. from patient's 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 settings the prescription should contain the name of the prescribed item, formulation, strength (if any) dosage and frequency, and quantity to be dispensed. If a medicine is to be taken as required, a minimum dose interval should be specified. The name should reflect the description in the BNF, should be written clearly and not abbreviated
    - the quantity prescribed should be appropriate to the patient's needs, bearing in mind the need to avoid waste. Some medicines are only available in patient packs

(or multiples thereof)[25] [26] and special containers[27] and the quantity contained should be prescribed, provided this is clinically and economically appropriate. This also ensures that an authorised patient information leaflet is supplied with the medicine

- 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) or litres, 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
- the unnecessary use of decimal points should be avoided e.g. 3mg not 3.0mg. Quantities of 1 gram should be written as 1g, less than 1 gram should be written in milligrams e.g. 500mg not 0.5g. Likewise, quantities less than 1mg should be written in micrograms e.g. 100 micrograms not 0.1mg. Use of the decimal point is acceptable to express a range e.g. 0.5-1g. ‘Micrograms’ and ‘nanograms’ should not be abbreviated. Similarly ‘units’ should not be abbreviated. See the BNF for the accepted list of abbreviations
- any warnings that will not be printed automatically onto the label for the medicine by the dispensing pharmacist (see the BNF for the list of warnings) must be written onto the prescription
- computer-issued prescriptions must contain the same patient-specific data as described above. The prescription must be printed in English without abbreviation, the dose in numbers, the frequency in words and the quantity in numbers in brackets e.g. 40mg four times daily (112) or by indicating length of treatment required. The name of the medicine must come from a dictionary within the

[25] 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.

[26] 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.

[27] 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.

computer's memory. The BNF gives advice if the medicine required is not listed in the dictionary

- in hospitals, prescriptions for inpatients 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 care settings, 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 following BNF descriptions
- **Diagnostic radiographers are recommended to prescribe generically, except where this would not be clinically appropriate or where there is no approved generic name** – see the BNF, the Drug Tariff and/or the marketing authorisation (summary of product characteristics) of the medicine. Local guidance should be followed and the personal formulary used to specify which medicines are to be prescribed. 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 compound or modified release medicines which have no approved non-proprietary name
- directions for use, 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)
- prescriber's signature and date and type of prescriber if not already printed
- on hospital prescriptions only: the diagnostic radiographer independent prescriber's name printed or handwritten in the box provided- to ensure that the dispensing pharmacist is aware who to contact if they have a query.

Annex C: Security and safe handling of FP10 prescription forms

The security of prescription forms is the responsibility of both the employing organisation and the prescriber. The most up to date detailed guidance for security of prescription forms can be found on the NHS Protect section of the NHSBSA website **www.nhsbsa.nhs.uk**. The following information is an extract from 'Security of Prescription Forms 2015.[28] The full document must be referred to when writing organisational policies.

The prescriber's responsibilities:

- Be aware that blank prescription forms in the wrong hands are like a blank cheque with an extremely high street value.
- Prescription form stock in possession of prescribers should always be stored securely when not in use.
- Prescribers should keep a record of the serial numbers of prescription forms issued to them. The first and last serial numbers of pads should be recorded.
- Prescribers should be encouraged to use prescription forms in number sequence order to aid tracking of usage, should a potential loss occur
- To reduce the risk of misuse, blank prescriptions should never be pre-signed.
- Patients, temporary staff and visitors should never be left alone with prescription forms or allowed into secure areas where forms are stored.
- Prescribers on home visits should, before leaving the practice premises, record the serial numbers of any prescription forms/pads they are carrying. Only a small number of prescription forms should be taken on home visits – ideally between 6 and 10 – to minimise the potential loss.
- Prescribers on home visits/working in the community should take suitable precautions to prevent the loss or theft of prescription forms. Keep them out of sight when not in use and do not leave any prescription forms in vehicles overnight.

[28] NHS protect (2015) Security of Prescription Forms http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/Security_of_Prescription_forms_Updated_August_2015.pdf

- Prescribers using the FP10PCD forms should exercise extra caution as there is greater potential for misuse of these forms.
- Blank or signed prescription forms should never be left at patients' homes, care homes or community pharmacies for GP or locum visits.
- Personalised forms which are no longer in use should be securely destroyed (e.g. by shredding) before being put into confidential waste, with appropriate records kept.
- Spoiled or cancelled prescription forms should be retained for audit purposes.
- In the event of a loss or theft of prescription form stock, local procedures should be followed and the practice manager/employer/non-medical prescribing lead, area team, Controlled Drugs Accountable Officer and the police should be notified as required. The incident should also be recorded on the organisation's incident reporting system. NHS Protect should also be notified at **prescription@nhsprotect.gsi.gov.uk** using the form at annex B of the Security of prescription forms guidance document.

Employer's responsibilities:

- Develop a prescription security awareness culture amongst practice staff and prescribers.
- Ensure that robust policies and procedures are in place to manage the effective security of prescription forms in the practice.
- Designate a member of staff to accept overall responsibility for overseeing the whole process involved – from the ordering, receipt, storage and transfer of prescription forms to their overall security (including access to them).
- Maintain an up-to-date list of all prescribers within the organisation to account for those who have left, moved employment/CCG area or been suspended from prescribing duties.
- Check deliveries of prescription form stock from the supplier whilst the delivery driver is present, to check order and amount are correct and packaging is sealed and unbroken.
- Report and investigate irregularities at delivery stage immediately with the supplier.
- Transfer prescription form stock to secure storage immediately.

- Ensure access to secure storage is restricted and all staff access to/from secure storage is recorded
- Maintain clear and unambiguous records on prescription form stock received and distributed.
- Patients, temporary staff and visitors should never be left alone with prescription form stock or allowed into secure areas where forms are stored.
- Prescribers conducting home visits should be alerted to and be mindful of the potential dangers associated with carrying around prescription forms or leaving them unattended.
- Personalised prescription forms which are no longer in use should be securely destroyed, e.g. by shredding, before putting into confidential waste.
- Spoiled or cancelled prescription forms should be retained for audit purposes.
- In the event of a loss or theft of prescription form stock, local procedures should be followed and the area team, Controlled Drugs Accountable Officer and the police should be notified as required. It should also be recorded on the organisation's incident reporting system. NHS Protect should also be notified at **prescription@nhsprotect.gsi.gov.uk** using the form at annex B of the Security of prescription forms guidance document.

NB All of the above requirements highlight the need for clear channels of communication, both within and between organisations

Annex D – Good Practice Example of Non-medical Prescribing Clinical Governance Frameworks

Non-Medical Prescribing: An Outline Governance Framework for Local Organisations

Adapted from document of the same name, written by M Cossey, North and East Yorkshire and Northern Lincolnshire SHA WDC and incorporating aspects of the Non-medical Prescribing Clinical Governance Framework written by L Wright and C Orme, Trent Strategic Health Authority; both first published in DH (2006) Improving Patients' Access to Medicines.

The development of non-medical prescribing (NMP) is a key policy initiative that aims to maximise benefits to patients and the NHS by:

- providing better access to medicines and
- better, more flexible use of the workforce skills

As diagnostic radiographer prescribing is rolled out nationally it is important that all those involved understand the responsibilities of individual practitioners, managers and organisations in ensuring safe and effective implementation and practice of NMP. Ensuring patient safety is an integral part of all healthcare providers' clinical governance arrangements. Key steps for NHS organisations to have in place to ensure the implementation of clinical governance include:

- Clear lines of responsibility and accountability for overall quality of clinical care
- Development of quality improvement programmes
- Management of risk
- Clear procedures to identify and remedy poor performance.

This framework sets out the key elements that organisations and individual practitioners should have in place or be in the process of addressing, in order to ensure that the development of NMP is implemented within a mechanism that develops safe and effective practice. The framework should be read in conjunction with any policies and procedures that local organisations have in place for implementing NMP or any general policies related to prescribing and medicines management. It should also be read in conjunction with any national or professional guidance issued by the HCPC and the Society and College of Radiographers.

1. Organisational Leadership and Strategy for Non-medical Prescribing (NMP)

Overarching statement: Clear lines of responsibility and accountability exist for all organisations in relation to the leadership, planning and implementation of NMP	
Governance arrangements required by organisations:	a) All organisations have a nominated named lead (or leads) for overseeing the development and implementation of NMP. Where different professional leads are in place co-ordination / networking between these leads is required to ensure consistency of approach to implementation and monitoring. The NMP lead should be linked directly with the Drugs and Therapeutics committee or equivalent. NMP should be linked into organisation prescribing and medicines management arrangements within the organisation where appropriate.
	b) Organisations should have in place an integrated policy around the strategic development and implementation of NMP. This should include: named leads for NMP, stakeholder and patient/public awareness initiatives, implementation plans for NMP, advice about training, internal arrangements for monitoring, mechanisms for application and training, processes for obtaining prescription pads, signposting to any relevant policies and procedures, and any other relevant local information.
	c) A co-ordinated database or register of all trained non-medical prescribers prescribing in that organisation should be maintained within all organisations. This database records all newly qualified prescribers; those employed by the organisation or another organisation commissioned to provide the prescriber and should note those NMPs who leave the organisation. It should also note the designated status of all NMPs (e.g. community practitioner nurse prescriber, independent/supplementary prescriber, supplementary prescriber) and the profession of the prescriber
	d) Systems are in place to inform non-medical prescribing lead in the Trust when new prescribers are employed and prescribers leave.
	e) A contact point within the organisation for any queries on the prescribing status of staff. i.e. from dispensing pharmacists
	f) Non-medical prescribing is an integrated part of organisational clinical governance arrangements and relevant action plans. Organisations must consider the impact of NMP on other related policies and procedures e.g. medicines-related error reporting.

Overarching statement: Clear lines of responsibility and accountability exist for all organisations in relation to the leadership, planning and implementation of NMP	
Governance arrangements required by organisations (cont):	g) All planned developments for NMP should be linked to strategic service development within the organisation For example: Long term conditions, improved access to medicines and services, practice based commissioning; service modernisation and redesign.
	h) Decisions to train individuals as NMPs should be linked to personal development plans and candidates should be assessed for competency related to knowledge and skills in their area of potential prescribing practice. the Competency Framework for all Prescribers is available from the Royal Pharmaceutical Society at https://www.rpharms.com/resources/frameworks/prescribers-competency-framework (Note: it is not intended that individuals are competent to "prescribe" prior to training but organisations should be assured that practitioners have the necessary clinical skills and knowledge in their area of practice which will enable them to prescribe safely and effectively once trained **OR** that CPD and additional training is planned to ensure these can be met. Organisations should also check that individuals would meet the necessary Higher Educational Institute (HEI) entry requirements).
	i) All plans to train NMPs should also include an assessment of: service specification, access to a prescribing budget (or equivalent in acute trusts / secondary care), development of necessary policies or documentation e.g. clinical management plans (CMPs)
	j) Links should exist between NHS organisations, HEIs and Health Education England to ensure effective monitoring of applications, funding, and quality of training, monitoring of numbers and professions trained, and attrition rates from modules.
	k) Ongoing support and network arrangements are in place for all NMPs including discussion of NMP at annual appraisal and access to relevant CPD. Job descriptions are amended to account for prescribing responsibilities.

2. Information governance and risk management of NMP

Overarching statement: Clear policies exist or links to existing policies are explicit for all managers and NMPs in relation to information governance and risk management of NMP.	
Governance arrangements required by organisations: (See also 1c above)	a) All NMPs should be linked to all organisational systems to ensure prescribers are kept informed of relevant clinical, therapeutic and prescribing information e.g. BNF, MHRA alerts, Drug Safety Alerts etc.
	b) A risk management plan is in place which will ensure that potential risks associated with extending clinical practice are recognised and minimised
	c) NMP practice is monitored through the same routes as medical prescribing (e.g. ePACT data, audit and feedback in primary care, local mechanisms in acute Trusts) and that information is available to practitioners and managers where appropriate, in line with internal arrangements.
	d) The parameters of an individual's prescribing should be agreed between the prescriber, their manager or local professional lead (e.g. the non-medical prescribing lead), and their employer. This is best carried out using a personal formulary approach which is a continuation from that developed during the course of study. The formulary should include the context in which the non-medical prescriber will prescribe the medicine and how the knowledge and competence to prescribe the medicine was achieved and is being maintained/developed.
	e) All NMPs are aware of the importance, how to and are encouraged to report adverse drug reactions via the national Yellow Card system
	f) All NMPs understand the importance of reporting Serious Untoward Incidents and are aware of the local mechanisms for doing this as well as National Reporting and Learning System (NRLS) reporting.
	g) NMP should be aware of and adhere to the organisational policy regarding relationships with the Pharmaceutical Industry
	h) All record keeping guidance and protocols/templates for prescribing practice are updated regularly as detailed within PCT/Trust policies e.g. CMPs should be revisited and amended where necessary and at least annually
	i) All medical prescribers should be aware of NMPs within the organisation and when and how they may interact with patients to ensure consistency of record keeping and continuity of patient care.

Overarching statement: Clear policies exist or links to existing policies are explicit for all managers and NMPs in relation to information governance and risk management of NMP.	
	j) Organisations (including GP practices) should keep records of prescription pad numbers linked to prescriber name for tracking any lost or stolen prescriptions, where prescription pads are used
	k) Organisations should review their policies related to medico-legal accountability and information made clear to NMPs regarding accountability, vicarious liability and personal indemnity. (Practitioners should also be advised to contact their professional regulatory bodies).
	l) The names of prescribers are annotated on their professional register, before they begin to prescribe

3. Audit and Quality Improvement

Overarching statement: Mechanisms should be in place to include NMP in relevant audit. Audit cycles and review processes should be employed to ensure that the implementation and development of NMP is progressing in a safe and effective manner that is benefiting patients and services.	
Governance arrangements required by organisations:	a) All review and updating of organisational prescribing and medicines supply policies include an impact assessment of NMP and are revised accordingly.
	b) All CMPs used by supplementary prescribers are reviewed (at least annually but more frequently where changes to patient's treatment plan, policy or evidence dictate) to ensure they are based on sound clinical evidence and are safe and cost effective.
	c) All NMP practice should be integral part of prescribing policy audit including adherence to NICE Guidance, other national or local clinical guidelines and any relevant local or national prescribing and medicines management policies.
	d) Evidence of tracking and monitoring arrangements should be in place to ensure the continuing competency of NMPs and their access to relevant, appropriate CPD. Systems should be in place to challenge competence issues.

4. Patient and Public Involvement

Overarching statement: There should be mechanisms in place in organisations to ensure patients and public are aware of NMP practice and have a say in any related developments or audit of NMP services.	
Governance arrangements required by organisations:	a) Patients and the public should be made aware of any developments in NMP which may alter services in order that they can make informed choices and understand what NMP means for them and the delivery of their care.
	b) Methods to include patient and public comments in any NMP service review should be standard practice within all organisations
	c) Patient / public information should be available in all organisations outlining what NMP is, what it means for patients and any specific services where NMP is being used in that area.
	d) Patient / public involvement forums should be briefed about NMP where relevant and appropriate and information provided in a useable format.

5. Responsibilities of Individual NMP practitioners and information resources

Whilst is understood that organisations need to have robust governance arrangements in place for their NMP staff, individual practitioners have responsibility for ensuring they are clinically competent for their role, undertake appropriate CPD, practice within the law and any agreed local policies and abide by the HCPC Standards of Conduct, Performance and Ethics[29]

Standards of prescribing are available on the HCPC website[30] Guidance for prescribing practice are available from the Society and College of Radiographers

The Competency Framework for all Prescribers, available from the Royal Pharmaceutical Society,[31] should be used by organisations, managers and individuals to assess competence to prescribe.

NICE currently purchases an annual supply of the British National Formulary and the British National Formulary for Children. Access to these resources is also available via 'Medicines Complete' and as an 'app' for mobile devices such as phones. Not all

[29] http://www.hcpc-uk.org/publications/standards/index.asp?id=38
[30] http://www.hcpc-uk.org/publications/standards/index.asp?id=692
[31] https://www.rpharms.com/resources/frameworks/prescribers-competency-framework

prescribing professionals may need their own hard copy and may find electronic access more convenient,

The Drug Tariff is also available for reference on the BSA website[32]

[32] http://www.nhsbsa.nhs.uk/PrescriptionServices/4940.aspx

Annex J: Checklist for Aspirant Prescribers and/or Organisations Introducing Prescribers

This document provides guidance for diagnostic radiographers seeking to undertake a prescribing role as part of their clinical practice. Safety is the paramount consideration when considering expanding practice, and independent prescribing can only be considered in context to this. The checklist can also be used by organisations considering introducing non-medical prescribing, or expanding current prescribing activities to diagnostic radiographers.
The following checklist provides a list of pre-requisite features required in order to move towards prescribing, and provides a link to the associate standards and legislation which may form part of your Professional Development Plan needed to ensure you meet the minimum criteria (and to maintain this). This checklist may be used regularly after qualification as an independent prescriber to ensure you still fulfil the requirements necessary to undertake independent prescribing.
You MUST be able to answer *YES* to all topics before considering non-medical prescribing.

Topic	**Evidence**	**Self-Assessment**			**Standards and Guidance Documents**
		Yes	Needs Development	No	
Your Clinical Role	Your employer is commissioned to provide clinical services which require independent prescribing (do you have a clear prescribing role)				
	Your role is currently limited by not being able to independently prescribe				
Your Professional Qualification and Post-registration experience	You are registered with the HCPC as a diagnostic radiographer and have no sanctions or conditions applied				
	You have an advanced practice qualification (typically MSc/other study at Masters level which fulfils the HEE definition of Advanced Practice) and have achieved the award within the last 6 years. or have evidence of continuous practice at that level if achieved longer than 6 years ago.				HEE - definition of Advanced Practice
	You are, and have been, practising in your area of expertise for at least 12 months				
	You have been qualified and registered for at least 3 years				

Topic	Evidence	Self-Assessment			Standards and
	You have evidence of post-registration study (for example, DipHE or PGDip)				
	You have a recognised qualification in, and experience of, diagnostics, physical examination and decision making skills relevant to your area(s) of prescribing practice.				
Your Organisation	You are employed by an organisation which is providing clinical services, and which has recognised a need for prescribing roles.				
	Your organisation has access to a pharmacist who is familiar with non-medical prescribing, and a Non-Medical Prescribing Lead.				
	Your organisation has an established non-medical prescribing policy, governance processes, and prescribing budget which meet the minimum best practice standards				
	Your organisation employs a Medical Director or other Clinician delegated to oversee non-medical prescribing				
	Your organisation has sufficient access to a Designated Medical Practitioner (DMP) who meets the criteria (NPC, 2005), and who can supervise trainee non-medical prescribers.				Web Link - NPC 2005
Your Prescribing Education	You meet all educational requirements for entering an approved non-medical prescribing programme and you have experience and competence in using medicines legislation for administration, possession and supply of medicines				
	You have read and understood the Royal				RPS - A Competency

Topic	Evidence	Self-Assessment			Standards and
	Pharmaceutical Society's competency framework				Framework for all Prescribers
	You have read and understood the Allied Health Professionals Federation Outline Curriculum Framework for independent and supplementary prescribing				AHPF Outline Curriculum Framework
	You have access to funding for non-medical prescribing education, or you are able to self-fund.				
	You have access to a DMP who can support your prescribing training				
Your CPD Plan and Opportunities	You have a detailed professional development plan which includes development as a prescriber. You are able to demonstrate attendance at relevant events, and a clear plan to take CPD opportunities in the future as a prescriber.				HCPC standards for continuing professional development. HCPC Standards for Prescribing
Your Supervision Plan and Opportunities	You are able to identify a suitable non-medical prescribing supervisor (buddy system), and have liaised with your non-medical prescribing lead (if available) to discuss supervision needs.				
Your Local Prescribing Network	You are aware of your local prescribing network and have discussed with your non-medical prescribing lead the role and function of this group.				
Your Ongoing Role and Career Plans	A clinical role is part of your career plan and you should seek to undertake prescribing as a core aspect of your clinical career for at least 3 years				
	You understand the implications of ceasing to prescribe as part of your practice within your role.				HCPC - prescribing training

Topic	Evidence	Self-Assessment			Standards and
Your Regulator	You understand the guidance issued by your regulator (HCPC)				HCPC Standards for Prescribing
	You understand and follow the Standards of Performance, Conduct and Ethics issued by the HCPC				HCPC Standards of Conduct, Performance and Ethics
	You understand and follow the Standards of Proficiency for Radiographers issued by the HCPC				HCPC Standards of Proficiency for Radiographers
Your Professional Body's Practice Guidance	You understand the role of the professional body – the College of Radiographers, and understand its role in relation to practice guidance, indemnity, CPD and professional standards				
	You have read and understood the Practice Guidance issued by the College of Radiographers				College of Radiographers: Practice Guidance for Independent Prescribing (DRAFT)