



**Draft Proposed Practice Guidance for Dietetic
Supplementary Prescribers
February 2015
(Draft Edition)**

Please note: This document provides guidance and advice based only on the *proposed changes to legislation* that would permit Supplementary Prescribing by Dietitians. Every effort has been made to ensure that the advice in this draft guidance document is accurate for the current legislative state, and all guidance must be taken on the basis of being application only in the presence of changes to legislation.

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

CONTENTS

Foreword	5
Introduction	5
Types of dietetic prescribing	5
Standards for prescribing	5
The scope of dietitian prescribing	6
Scope of practice and competency in prescribing	7
Registration and Professional Indemnity Insurance (PII)	8
SECTION 1 – PRINCIPLES OF GOOD PRESCRIBING PRACTICE	9
Practice Guidance 1: License to prescribe	9
Practice Guidance 2: Accountability	9
Practice Guidance 3: Assessment	10
Practice Guidance 4: Clinical need	11
Practice Guidance 5: Consent	11
Practice Guidance 6: Communication	12
Practice Guidance 7: Record keeping	13
Practice Guidance 8: Evidence-based prescribing /prescribing in the patient's best interests	14
Practice Guidance 9: Delegation	14
Practice Guidance 10: Information given to patients about their medicines	14
Practice Guidance 11: Clinical management plans	15
Practice Guidance 12: Transcribing	15
Practice Guidance 13: Electronic prescribing	16
Practice Guidance 14: Writing NHS prescriptions	16
Practice Guidance 15: Writing private prescriptions	17
Practice Guidance 16: Reviewing prescriptions	17
Practice Guidance 17: Repeat prescriptions	17

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

SECTION 2 – SPECIAL PRESCRIBING CIRCUMSTANCES	18
Practice Guidance 18: Family, friends and close colleagues	18
Practice Guidance 19: Children	18
Practice Guidance 20: Unlicensed medicines	19
Practice Guidance 21: Mixing of medicines	19
Practice Guidance 22: Off-label use of medicines	19
Practice Guidance 23: Remote prescribing	19
Practice Guidance 24: Prescribing on the recommendation and/or at the request of others	20
Practice Guidance 25: Controlled drugs	20
SECTION 3 – MEDICINES GOVERNANCE	22
Practice Guidance 26: Instructions for supplying and/or administration	22
Practice Guidance 27: Dispensing	22
Practice Guidance 28: Storage	22
Practice Guidance 29: Transportation	22
Practice Guidance 30: Disposal	23
Practice Guidance 31: Error reporting	23
Practice Guidance 32: Reporting unexpected effects and adverse reactions	23
Practice Guidance 33: Access to supplies of medicines	23
Practice Guidance 33: Complementary, herbal and homeopathic products	23
SECTION 4 – CLINICAL GOVERNANCE	25
Practice Guidance 35: Governance structures	25
Practice Guidance 36: Clinical audit	25
Practice Guidance 37: Prescribing analysis	25
Practice Guidance 38: Learning from incidents and errors	26

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

Practice Guidance 39: Risk management	26
Practice Guidance 40: Continuing professional development	26
Practice Guidance 41: Poor performance	26
Practice Guidance 42: Safety of NHS prescription pads	26
Practice Guidance 43: Links with pharmaceutical companies /conflict of interest	27
Practice Guidance 44: Gifts and benefits	27
Practice Guidance 45: Checking registrations and annotations	27
Appendix	28
Glossary	31
Acknowledgements	36
Membership of Allied Health Professionals Medicines Project Education Working Group	
Membership of Allied Health Professionals Medicines Project Medicines Project Board	37

THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE BEFORE IT CAN HAVE EFFECT

FOREWORD (to be inserted for final document)

Introduction

This Practice Guidance provides information which should underpin the decision-making and actions of dietitians who are annotated with the Health and Care Professions Council (HCPC) as supplementary prescribers.

This document is “guidance”. “Guidance” is information which a dietitian has a duty to consider and is expected to take into account as part of their decision making process. This document provides advice on the behaviours and conduct expected of dietitians who are annotated on the HCPC register as a Supplementary prescriber. Throughout this document, the use of the word ‘**must**’ indicates a legal and/or regulatory requirement and describes a mandatory action and/or behaviour. The use of the word ‘**should**’ indicates behaviours and/or actions that would be expected to occur in all normal circumstances. Each section of this guidance carries equal weight and the document is not ordered in any priority.

If a dietitian prescriber deviates from the guidance in this document, the clinical judgment for so doing must be carefully recorded. You must comply with this Practice Guidance, other guidance issued by The British Dietetic Association, and with any statutory requirements applicable to your prescribing practice. Failure to do so may put your HCPC registration at risk if concerns are raised about your fitness to practise. A dietitian prescriber will be expected to justify any decision to act outside the terms of this guidance and, in particular, if the dietitian prescriber undertakes a course of action not recommended by this guidance there must be robust reasons for doing so.

The advice in this document applies to all sectors of health and social care provision in the United Kingdom where prescribing activities occur, as permitted by the prescribing laws in each of the Home Countries separately. The law may not be comparable across England, Scotland, Wales and Northern Ireland. It is up to the individuals to satisfy themselves of the law in the UK country in which they work and that good governance procedures are in place in their workplace setting.

At the current time, prescribing is not permitted by dietitians outside the UK and therefore a dietitian permitted to supplementary prescribe in the UK cannot perform this activity outside UK jurisdiction.

It is important to note that the guidance in this document is draft. Changes in legislation will be necessary to enable dietitians to become supplementary prescribers.

Types of dietetic prescribing

Appropriately qualified dietitians who are registered with the HCPC will have their HCPC entry annotated to describe their status as a prescriber once they have completed an approved non-medical prescribing course. For the foreseeable future the HCPC will annotate the SP and IP qualifications separately.

THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE BEFORE IT CAN HAVE EFFECT

Subject to public consultation and changes in legislation, Dietitians will be able to qualify as supplementary prescribers (SP). Dietitians qualifying as supplementary prescribers will be annotated as SP only. A supplementary prescriber can only prescribe under a Clinical Management Plan, they cannot prescribe independently.

Standards for prescribing

The HCPC defines the standards for prescribing that are required for independent prescribing by physiotherapists and podiatrists and supplementary prescribing by radiographers. The standards will be extended to include supplementary prescribing by dietitians, subject to a change in legislation. The standards include the proficiencies required to prescribe safely and effectively. These proficiencies are in addition to the proficiencies that apply to non-prescribing dietitian practice.

<http://www.hcpc-uk.org/publications/standards/>

The scope of dietitian prescribing

Dietitians are essential to delivering fast and reliable diagnoses of nutritional disease, as well as management and palliative treatment and care for patients with long term conditions, gastrointestinal disorders and cancer. The purpose of individual dietitian prescribing is to support and enhance the delivery of dietetic interventions when diet, lifestyle and medication are the key components of their condition and its management. The breadth of the profession as a whole is vast, and encompasses the diagnosis, treatment and management of a range of nutritional disorders and long term conditions such as diabetes, kidney disease, pancreatic insufficiency and gastrointestinal disorders. The dietetic workforce delivers nutritional services in a range of health and social care settings across the UK. A large majority of patients will be referred for nutritional advice and treatment during the course of their disease and are key to the delivery of successful clinical outcomes.

Dietitian supplementary prescribers should not be asked to prescribe for patients to make up for short-falls in other professional prescribing groups.

Individual dietitians will develop their own scope of practice as they determine, depending on their role and the demands of service.

Advanced dietetic practitioners work mainly in acute and clinical community settings. Dietitians fundamentally ensure sufficient energy and nutrients to maintain normal physiological functions and permit growth and replacement of body tissues; and offer advice that will provide the best protection against the risk and progression of disease. Dietary modification may range from detailed guidance based on adjustment of food choice or complex manipulations necessitating artificial diets directly into the patient's vein. Whatever the intervention, it is important to ensure that alteration of one aspect of the diet does not inadvertently create other dietary imbalances, deficiencies or drug nutrient interactions that could create other health risks.

Dietitians are not permitted to prescribe medicines for animals.

THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE BEFORE IT CAN HAVE EFFECT

The future scope of supplementary prescribing practice by dietitians is as described below:

Subject to the response to a full public consultation and changes to medicines legislation it is proposed that the dietitian supplementary prescriber may prescribe any medicine, within national and local guidelines for any condition within the practitioner's area of expertise and competence, and within the overarching framework of nutritional treatment in long term conditions, cancer and gastrointestinal disorders. They may also prescribe individual medicines to be mixed prior to administration but only where that preparation forms part of the agreed clinical management plan for an individual patient, and may prescribe controlled drugs as set out in regulations, and included in the patient's clinical management plan (CMP).

Scope of practice and competency in prescribing

Medicines use and prescribing activity is fully accepted as being within the overall scope of the dietetic profession as a whole. It will be part of an individual's scope of practice subject to appropriate education, training and competence in prescribing activities.

The post-registration educational programme in prescribing ensures dietitians are equipped with the principles of prescribing to enable them to be safe, effective and cost-effective prescribers. Dietitian supplementary prescribers should ensure that they are able to apply the prescribing principles to their own area of practice, bearing in mind that this may be a requirement for continuing registration. Dietitian supplementary prescribers must only prescribe within their scope of practice and understand that if they change clinical areas they will require a period of training before they are competent to prescribe in a new area of practice.

An individual's scope of dietetic practice must fall within the overall scope of the profession; therefore an individual's dietetic-prescribing practice must fall within the overall prescribing scope of the profession. At the current time, prescribing is not permitted by dietitians outside the UK and therefore a dietitian permitted to supplementary prescribe in the UK cannot perform this activity outside UK jurisdiction.

Prescribers must have sufficient education, training and competence to:

- assess a patient's clinical condition
- undertake a thorough history, including medical history and medication history (including over-the-counter medicines and complementary therapies), and allergy status
- diagnose where necessary
- decide on management of the presenting condition and whether or not to prescribe and/or refer
- identify appropriate products of medication as required
- advise the patient on risks, benefit and outcomes of the medication
- prescribe if the patient agrees
- monitor the patient's condition, including any response to the medication prescribed
- give lifestyle advice as appropriate
- refer to other professionals if necessary.

**THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT**

Prescribing is a professional skill that applies equally to all professions who undertake such responsibility. There is a unified single competency framework for all prescribers published by the National Prescribing Centre (Now part of the National Institute for Health and Care Excellence (NICE)). NB. NICE are currently undertaking a consultation to include non-medical prescribing competencies into the Medicines Optimisation Guidance.

http://www.npc.co.uk/improving_safety/improving_quality/resources/single_comp_framework_v2.pdf

The BDA expects members to be able to demonstrate how they meet this competency framework.

Registration and Professional Indemnity Insurance (PII)

From July 2014, HCPC registrants must have proof of adequate indemnity to practice in order to maintain registration.

Dietitians who are members of The British Dietetic Association (BDA) benefit from personal Professional Indemnity Insurance (PII) as part of their membership of the BDA. In order for their PII to be in force (subject to the terms of the policy), the BDA member must:

- hold current registration with the HCPC
- hold a current BDA membership in a category that provides PII cover at the time that treatment of advice is given.
- be practising lawfully
- be practising within the overall scope of the profession of dietetics.

Prescribing is accepted as within the overall scope of the dietetic profession and owing to the requirement for a dietitian to be practising lawfully for PII to be in force, for supplementary prescribing to be covered as part of an individual's PII the member must:

- have an HCPC annotation showing their prescribing status as a supplementary prescriber.

BDA members need to inform the BDA of their prescribing status, and they must not prescribe until they are satisfied that their HCPC entry has been updated.

Dietitians who are not members of the BDA will need to ensure they have adequate insurance or other indemnity arrangement in place for their practice. They may be personally liable for any costs if they are not adequately or appropriately insured. Many employers now expect individual health professionals to hold their own personal insurance in addition to any employer vicarious liability insurance that may be in force. Dietitians who wish to join the BDA in order to gain PII and a variety of other benefits and professional support are very welcome and should contact www.bda.uk.com.

For further information about PII see website

<https://www.bda.uk.com/professional/workforce/insurance>

NOTE:

The guidance in this document is draft. Changes in legislation will be necessary to enable dietitians to become supplementary prescribers

SECTION 1 – PRINCIPLES OF GOOD PRESCRIBING PRACTICE

This section provides guidance on good prescribing practice. Having achieved the competencies for supplementary prescribing, dietitians are expected to follow this advice in their practice. The guidance provided in this document applies to all settings in which a dietitian may prescribe – within the NHS, private practice, prison service, armed forces, sporting settings or any other health and social care sector.

The BDA considers it good practice that, where dietitians are employed, the employing organisation signs off all protocols and procedures. Where possible, dietitian supplementary prescribers should follow organizational-level policies and procedures and should only create local department-level procedures where no national or organizational policy or procedure is in existence.

Practice Guidance 1: License to prescribe

1.1 You must only prescribe once you have successfully completed an HCPC approved supplementary prescribing programme and had your entry on the register of the Health and Care Professions Council annotated to show your prescribing status as a supplementary prescriber.

1.2 You should comply with this Practice Guidance, other guidance issued by the BDA, and with any statutory requirements applicable to your prescribing practice. Failure to do so may put your HCPC registration at risk if concerns are raised about your fitness to practise.

1.3 You must only prescribe within your own defined scope of practice and clinical specialty.

1.4 You must understand which legal framework you are using to supplementary prescribe medicines, understand which types of medicine you are permitted to prescribe within that framework.

Practice Guidance 2: Accountability

2.1 You are professionally accountable for your own supplementary prescribing decisions, including actions and omissions. You cannot delegate this accountability to any other person nor can any other person accept accountability on your behalf for your actions. As a supplementary prescriber you are wholly responsible for your decision to prescribe the medicines listed within the written CMP. The content of a CMP is developed and agreed jointly by the doctor and supplementary prescriber (and the plan has to be agreed with the patient)

2.2 You must only prescribe within your level of education, training and competence. You must act in accordance with the HCPC's Standards of proficiency, HCPC Standards of conduct performance and ethics, the HCPC Standards of prescribing and the BDA Code of Professional Conduct.

**THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT**

2.3 If you move to another area of practice you may need to undertake further training in order to establish your competency to prescribe in your new clinical specialty.

2.4 Your employer may operate a specific prescribing formulary and may not allow you to prescribe outside of this formulary. This restricted formulary would only apply to your practice for that employer.

2.5 You must also inform the relevant authorities if you have any formal regulatory restrictions placed on your prescribing activity, for example, if the HCPC places certain conditions on your practice.

Practice Guidance 3: Assessment

3.1 In order to prescribe for a patient you must satisfy yourself that you have undertaken a full assessment of the patient, including a thorough history and, where possible, accessing a full clinical record including medication and allergy history. This process may involve carers, especially if the patient has additional needs.

3.2 You should prescribe only where you have relevant knowledge of the patient's health and medical history commensurate with the prescribing decisions you are taking.

3.3 You should ensure you have considered the patient's current medication and any potential interactions with other medicines.

3.4 You should take steps to ensure that the patient is not suffering from any medical condition, allergy or receiving any other treatment, that would make the prescription of any medicine unsuitable or dangerous.

3.5 You should ensure you consider the effects of your patient's lifestyle which may affect the safety of the medicines you prescribe. This will include:

- the effects of smoking, caffeine, alcohol
- the effects of 'recreational' or 'street' drugs or those used to enhance physical or sporting performance
- the effects of over-the-counter medicines including herbal preparations.

3.6 Where necessary you should have the ability to request and/or have access to the results of additional appropriate tests. These tests should be relevant to the presenting condition and/or appropriate to the prescribing decisions to be made in order to assist your prescribing decisions. These may include:

- blood haematology
- blood biochemistry tests eg liver, thyroid and/or kidney function
- gastrointestinal investigations.

3.7 You may be asked to assess and prescribe during out-of-hours or on-call settings for patients for whom you have a CMP in place. You should refer to another appropriate prescriber if you do not fully understand the implications of your prescribing actions even though you may be able to take a thorough and appropriate history which leads to a diagnosis.

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

Practice Guidance 4: Clinical Need

4.1 You must only use supplementary prescribing where you have assessed the patient and there is a genuine clinical need for the prescription of medicines.

4.2 You should consider the circumstances in which you may decide to withdraw medication, cease to continue prescribing a named medication or alter the prescribed dose of a medication. Patients may also wish to discuss with you withdrawal from medication. Any withdrawal from medicines needs to be planned in partnership with the patient and the doctor, and anyone involved with their care and take place over an agreed time period.

4.3 You should never use supplementary prescribing for your own convenience, or simply because a patient demands that you do.

4.4 You should prescribe in the patient's best interests and achieve this by reaching agreement with the patient and the doctor on the use of any proposed medicine where possible. The amount of information you discuss with your patient will vary according to the nature of the patient's condition, the risks and benefits of the medicine and any alternatives, and the patient's wishes, but in all circumstances will include the provision of "sufficient information" to allow the patient to make an informed choice ie to give their informed consent. You should aim to:

- establish the patient's priorities, preferences and concerns
- discuss alternative treatment options available to the patient
- satisfy yourself that you have enough relevant information to make a prescribing decision
- satisfy yourself that the patient understands how to take the medicine as prescribed.

4.5 You should only use supplementary prescribing for patients who are part of your own caseload or under your own care.

Practice Guidance 5: Consent

5.1 You should explain your role as a non-medical prescriber to the patient. You must provide your patient with "sufficient information" relating to the risks, benefits and significant and material outcomes of the medicines management you are considering as well as the comparative risks of alternative treatment options to medication that may be considered in order that the patient can give their informed consent to treatment.

5.2 You should be aware of the variety of social, cultural and religious factors that may impact upon the choices your patient makes in agreeing prescribing decisions with you.

5.3 You should act in accordance with Department of Health, the BDA and employer guidance on the obtaining and documenting of consent.

5.4 The patient has the right to refuse to accept any medication you propose to prescribe for them, but if they do so you should explain the risks, benefits and outcomes of their decision.

5.5 The patient should be provided with any relevant Patient Information Leaflet (PIL) about the medicine you propose to prescribe. This would normally be provided with the medicine, but if not, the PIL or equivalent should be provided by the supplementary prescriber.

**THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT**

Practice Guidance 6: Communication

6.1 You should communicate effectively, using the most appropriate media, with other practitioners involved in the care of the patient. This includes communication across NHS/private practice boundaries where necessary. You should refer the patient to another prescriber when it is necessary to do so.

6.2 Supplementary prescribing decisions should be made in partnership with the patient, where practicable to do so. This will include taking into account the patient's personal views and beliefs and discussing prescribing and medication decisions in relation to these. . You should ensure that patients have understood what they have been told and the consequences of decisions that have been agreed.

6.3 Prescribing is not an activity that occurs in isolation. Prescribing information must be shared with other health professionals who need to know the information for the benefit of the patient and this will include the patient's GP. You should decide the best methods of sharing this information. Where possible, you should have access to other professionals' prescribing decisions where they impact upon your own decisions. This will include communication across NHS-private practice boundaries where it is necessary to ensure that clinicians have appropriate information to inform their prescribing practice.

6.4 You must inform anyone else who may be in a position to prescribe for that patient of your actions to avoid prescribing errors. This is most likely to be the patient's general medical practitioner, but may also include other health and social care professionals. If the patient refuses to consent to you sharing such information you should offer an explanation of the risks of not doing so. If the patient continues to refuse to give consent, you should consider which course of action (including not to prescribe) would be in the best interests of the patient. This must be documented in their records.

6.5 You should know what medication the patient is currently taking including over-the-counter and herbal preparations before prescribing new medicines and you should take steps to ensure you have access to the primary source of prescribing information, which is likely to be the GP record.

6.6 When sending patient data, it is vital that the data is secure, and that the risk of data loss (including misdirection) is minimised. The Health & Social Care Information Centre have produced a detailed Information Governance Toolkit¹ regarding the safe transfer of patient data which lists the most commonly used methods of communication along with the minimum standards required for safe and secure data transfer. These include:-

- Verbal Communications: The security and confidentiality of telephone and personal conversations should be considered within the organisation's policy and procedures (eg confidentiality code of practice) and included in staff training. Staff should be mindful of the need to maintain security and confidentiality when discussing personal or other sensitive information

¹Department of Health (2010) *IG Toolkit Version 8 Information Security Assurance Requirement 322 Detailed Guidance on Secure Transfers* (Online) Available at:

https://www.igt.hscic.gov.uk/KnowledgeBaseNew/DH_NHS%20IG%20-%20Detailed%20Guidance%20on%20Security%20Measures%20for%20Information%20Transfers.pdf

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

- Telephone answering machines: This can be used where the recipient is known (i.e. GP practice) and the message will be retrieved in an appropriate manner. Best practice suggests using password protected voicemail wherever possible.
- Faxing: Patient data which is faxed should be done following the NHS IG Safe Haven principles.
- Email: Emails containing patient identifiable data should only be sent using (and receiving) NHSmail email accounts or other approved government email domains.
- Postal/Courier Services: Items must be tracked and traceable, and should include arrangements for redirected or undeliverable items
- Portable storage devices (USB Sticks): Use of these devices must only be used following an Information Risk Assessment
- Internet protocol (IP) phones (including systems such as Skype): These should only be used “point to point” within the secure N3 network. (It is accepted that clinician/patient conversations occur using this method but it is not advised for conversations about patients/clients between healthcare professionals)
- Web Based Applications: Movement of patient data within electronic systems must be encrypted and comply with the Confidentiality NHS Code of Practice.
- Short Messaging System (SMS “texting”): SMS should not be used to convey patient data due to the lack of secure transfer methods and retention of sent data.

Practice Guidance 7: Record keeping

7.1 This practice guidance relates specifically to the record keeping of your prescribing actions. You should refer to other standards and guidance for information relating to clinical record keeping in general. Prescribing activity (eg writing an FP10, using a hospital based treatment/drug card or using an electronic prescribing application, or a private prescription) should occur at the time of contact with the patient in order to ensure contemporaneous activity is captured in the clinical record.

7.2 Documentation of the supplementary prescribing activity should be recorded in clinical records at the time of treatment of the patient. It is not good practice to document prescribing activity after the event eg at the end of the clinic session or the end of the day. Only in exceptional circumstances should documentation be delayed, but in any event the delay should not exceed 24 hours.

7.3 In supplementary prescribing, the doctor/dentist and supplementary prescriber must share access to, consult and, wherever possible, use the same common patient record.

7.4 Records must include the prescription details, together with relevant details of the consultation with the patient.

7.5 Your records should show that you have communicated with the primary healthcare record keeper (usually the GP) especially with regard to repeat, ongoing or withdrawn prescriptions. For hospital in-patients this may be in the form of the hospital discharge letter and/or clinic letter.

**THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT**

Practice Guidance 8: Evidence based supplementary prescribing / Supplementary prescribing in the patient's best interests

8.1 You should ensure that your supplementary prescribing practice is appropriate, responsible and in the patient's best interests. Every medicine that is prescribable will have an evidence base recommending its use and you should be aware of any NICE guidance and, if appropriate, the current evidence supporting the use of a given medicine.

8.2 You should prescribe according to the available evidence base. Evidence-based prescribing involves the application of the best available evidence when making prescribing decisions. Reference to the evidence base can minimize the risk of adverse drug reactions and ensure the most appropriate medicine is chosen for a patient's needs.

8.3 You should use national sources of evidence as your primary source of evidence-based prescribing. Where you can clearly demonstrate that a national source of evidence is not available, then locally agreed practice-based evidence or protocols should be followed. When supplying antibiotics you should consider antimicrobial stewardship and follow local policies for antibiotic use. The local policy is required to be based on national guidance and should be evidence-based, relevant to the local healthcare setting and take into account local antibiotic resistance patterns. They should cover diagnosis and treatment of common infections and prophylaxis of infection. As with the National Prescribing Centres (now part of NICE) competencies for all prescribers^[1], the 2013 Public Health England / Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Antimicrobial Prescribing and Stewardship Competencies^[2] should be used by any independent prescriber to help develop their prescribing practice at any point in their professional development in relation to prescribing antimicrobials.

8.4 You should ensure your prescribing is appropriate and that patients have enough information to make an informed choice. You should consider the following factors to ensure you:

- are familiar with the current national sources of evidence for the medicine
- are familiar with the current national sources of evidence for the condition you are treating which may also include current evidence for which medicine groups should be used, or not used, and a hierarchy of medicines use
- have taken an appropriate assessment of the patient
- have taken into account the patient's preferences and expressed wishes with regard to medicines use
- have prescribed the appropriate dose for your patient's age and weight.

Practice Guidance 9: Delegation

9.1 You may delegate the administration of a medicine that you have prescribed to another healthcare worker or to the patient themselves. You remain accountable for your supplementary prescribing decision and you are also accountable for your decision to delegate the task of administration to someone else including the patient. This includes your assessment that the person is competent to carry

^[1] National Prescribing Centre provided by NICE (2012) *A Single Competency Framework for all Prescribers*.

London: NICE http://www.npc.co.uk/improving_safety/improving_quality/resources/single_comp_framework_v2.pdf

^[2] Department of Health and Public Health England (2013) Antimicrobial prescribing and stewardship competencies <https://www.gov.uk/government/publications/antimicrobial-prescribing-and-stewardship-competencies>

THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE BEFORE IT CAN HAVE EFFECT

out the task and has received sufficient training to carry out your instructions. You are not accountable for the outcome of an action performed by another person.

9.2 Where this information is not clearly identifiable from your written prescription then the information should be separately recorded in the patient record.

Practice Guidance 10: Information given to patients about their medicines

10.1 Patients, or those authorising treatment on behalf of the patient, should be given sufficient information as they require in order for them to make an informed choice with regard to prescribing decisions. You should include:

- diagnosis giving rise to prescribing need
- any known serious or common side effects of the proposed medicine
- how the medicine works
- how long to take the medicine for
- how to stop taking the medicine.

10.2 Information provided should be appropriate to the patient's levels of understanding.

10.3 Where practicable, you should support information given to your patients in writing.

10.4 You should tell the patient that their medicine will come supplied with a manufacturer Patient Information Leaflet (PIL) or a photocopy of the original PIL, which will give them additional information. In in-patient settings where the PIL is not routinely supplied, patients can request such information if they wish.

Practice Guidance 11: Clinical management plans (CMP)

11.1 As a supplementary prescriber, you must prescribe in accordance with a patient's individual written clinical management plan (CMP). For a CMP to be legally valid, the independent prescriber must be a medical doctor or a dentist.

11.2 Where standard written CMPs are in place as a starting point, you must tailor them to reflect the individual patient's personal, medical and medicines history. The CMP must be agreed with you by a medical prescriber, and with the consent of the patient, before supplementary prescribing begins. This could be in the form of a signature, or for an electronic record, a recordable indication of agreement.

11.3 The supplementary prescriber and independent prescriber may agree to modify a CMP in the light of a patient's changing needs, and may also decide to terminate the use of a CMP if it is no longer appropriate. The supplementary prescriber must always refer back to the independent prescriber if the patient's condition changes such that the current CMP is no longer appropriate.

11.4 Within supplementary prescribing you must never prescribe medicines in the absence of a written clinical management plan which has been agreed with the independent prescriber and with the consent of the patient. The independent prescriber may agree verbally to a CMP providing that it is confirmed by fax or secure email in writing before prescribing occurs, and is formally recorded within two working days.

THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE BEFORE IT CAN HAVE EFFECT

Practice Guidance 12: Transcribing

In some circumstances you may be asked to transfer medicines information from one document to another, a process known as transcribing.

Transcribing should not be a routine or regular occurrence. If you transcribe, you are accountable for your actions and omissions and this will include any errors you make in transferring the information from one document to another.

You should satisfy yourself that transcribing is a necessary activity that cannot be eliminated by reviewing and improving the care pathway. If transcribing does occur, you should ensure that the activity meets local clinical governance requirements.

Any transcription must include

- Patient's full name
- Date of birth
- Name of medicine
- Drug dosage, strength, timing, frequency and route of administration.

Practice Guidance 13: Electronic prescribing

13.1 If you prescribe using e-Prescribing software you should also be using a compatible electronic clinical record software package that allows your prescribing activities to be referenced and cross-checked against the main electronic clinical record. The purpose of electronic prescribing is to reduce medicines errors and reduce patient morbidity and mortality; therefore the prescribing record should be linked to the clinical record.

13.2 You may prescribe via computer-generated prescriptions providing the necessary software is available.

13.3 A traceable audit trail of your prescribing actions should be maintained.

13.4 You must never print off blank prescriptions in advance and then store them for future use.

Practice Guidance 14: Writing NHS prescriptions

14.1 In order to write an NHS prescription, the medicine must be permitted to be prescribed at NHS expense. You should check the BNF if you are not sure if a medicine is available on the NHS. If a medicine is not available at NHS expense, it can only be prescribed against a private prescription.

14.2 Your written prescription must contain the information required by law such as:

- your signature in ink
- your name and workplace address
- the date on which the prescription was signed by you and/or the date after which it can be dispensed
- your profession
- the name and address of the patient
- the age of the patient if they are under 12 years old.

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

- your designation as a supplementary prescriber

14.3 The names of the medicines must be written clearly using approved names only. You must not use abbreviations in the name of the medicine.

14.4 A non-repeat prescription is valid for six months after the date of signing, however you should ensure that the medicines prescribed are appropriate for the patient's needs as you have assessed them, therefore the reasons for any significant delay between assessment and prescription dispensing should be documented.

14.5 You must only write prescriptions for your NHS patients on an in-patient drug chart, an in-patient hospital discharge and/or clinic letter, an in-patient To-Take-Out (TTO) form, an FP10 for out-patients or form provided by your local trust/pharmacy. You must only use the FP10s that have been issued specifically to you for your NHS practice and that show your name and HCPC registration number on them. All the details listed in section 13.2 must be included when completing the prescription.

14.6 You must never tamper with an existing prescriber's details on a prescription form or add your own prescribing details.

14.7 You must sign your prescriptions immediately after they are produced. If this is not possible (e.g. the prescription is printed in a dispensary away from your clinic room), the unsigned prescriptions must be securely stored until you can sign them. You must sign them within 24 hours.

14.8 You must never sign blank prescription forms in advance and then store them for future use.

Practice Guidance 15: Writing private prescriptions

15.1 You may write a private prescription for a patient who is receiving non-NHS care provided there is a CMP in place. Private prescriptions can be written for medicines that are not available on the NHS. You must not use an NHS prescription form to prescribe medicines privately. A private prescription cannot be used for NHS funded care.

15.2 A private prescription may be written on any document and it must contain the following:

- your signature in ink
- your name and workplace address
- the date on which the prescription was signed by you and/or the date after which it can be dispensed
- your profession
- the name and address of the patient
- your designation as a supplementary prescriber
- the age of the patient if they are under 12 years old.

15.3 The names of the medicines must be written clearly using approved names only. You must not use abbreviations in the name of the medicine.

15.4 NHS prescription forms (FP10s) must not be used to meet the medicines needs of patients whose healthcare is being provided by the non-NHS sector. Patients receiving medicines as part of private healthcare provision are liable for the actual costs of the medicines and any private prescription charge.

THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE BEFORE IT CAN HAVE EFFECT

You must not ask the patient's GP to prescribe medicines at NHS expense which are subsequently to be administered as part of private healthcare provision.

Practice Guidance 16: Reviewing prescriptions

You should review a patient's medication when you are starting a new medication, stopping a medication or changing a dose of a current medication.

Practice Guidance 17: Repeat prescriptions

17.1 Repeat prescriptions are valid for six months and, unless otherwise specified in writing on the prescription, the medicine may be dispensed twice within the validity of the prescription (with the exception of contraceptives which may be dispensed six times). You should ensure that you review your patient's medication at regular intervals to ensure the prescription remains appropriate for your patient's needs.

17.2 If you issue repeat prescriptions you must ensure that you prescribe safely and responsibly. Before signing repeat prescriptions you must be satisfied that it is safe and appropriate to do so. You should review repeat prescriptions regularly and do not issue medicines for longer than is clinically required. You must ensure the correct dose is prescribed for medicines where the dose varies according to the stage of the treatment.

SECTION 2 – SPECIAL PRESCRIBING CIRCUMSTANCES

Practice Guidance 18: Family, friends and close colleagues.

18.1 You must not prescribe medications to treat yourself. You should be registered with your own medical and/or health practitioner who will be objective in providing you with good care.

18.2 You should not prescribe for those close to you. People close to you may include your immediate family (parents, grandparents, children, grandchildren, siblings, aunts, uncles and first cousins), someone with whom you have an intimate personal relationship, your friends, and may also include colleagues with whom you regularly work. People you prescribe for should be formally on your caseload as your patient and in partnership with the doctor with a CMP in place.

Practice Guidance 19: Children

19.1 Medicines are potent treatments and prescribing them can present significant risk to patients. This is especially so for children whose responses may differ from adults. You must have relevant education, training and competence in treating children in order to supplementary prescribe for them. You should recognise the unique implications of prescribing for children and young people. Caution should also be taken when prescribing for pregnant and lactating women.

19.2 You must make reference to the following documents that address medicine management issues in paediatrics:

- The BNF for Children (England/Wales/Scotland) at www.bnfc.org

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

- Medicines Standard: National Service Framework for Children, Young People and Maternity Services at www.dh.gov.uk under Policy and Guidance, Health and Social Care Topics, Children Services
- Medicines Standard: National Service Framework for Children, Young People and Maternity Services (Wales)
- Royal College of Paediatrics and Child Health – information on use of licensed and unlicensed medicines at www.rcpch.ac.uk/publications
- Scottish Executive - The Administration of Medicines in Schools and The Right Medicine: A Strategy for Pharmaceutical Care in Scotland
- Scottish Intercollegiate Guidelines Network (SIGN) Guidance at www.sign.ac.uk
- DHSSPS – Medicines Management Standard
- Department of Health (DH) – Every Child Matters (2004)

Practice Guidance 20: Unlicensed medicines

20.1 Medicines are classified as unlicensed if they do not hold a UK Marketing Authorization issued by the MHRA. If you are a dietitian supplementary prescriber you may prescribe unlicensed medicines that are defined within a written CMP, but if you decide to do so you must:

- be satisfied that an alternative, licensed product would not meet the patient's needs
- be satisfied that there is a sufficient evidence-base for using the unlicensed medicine to demonstrate safety and efficacy
- record the medicine prescribed and the reasons for using an unlicensed product in the patients notes
- clearly explain to a patient if you will be prescribing unlicensed medicine.

Practice Guidance 21: Mixing of medicines

21.1 Medicines are also rendered unlicensed if they are mixed together prior to administration. The law defines “mixing” as the combination of two or more licensed medicines together where one is not the vehicle for administration of the other for the purposes of administering them to an individual patient.

21.2 If you are a dietitian supplementary prescriber you may prescribe medicines to be mixed, and direct others to mix medicines that are defined, and specified for mixing, within a written CMP.

Practice Guidance 22: Off-label use of medicines

22.1 An off-label medicine does hold a UK Marketing Authorization issued by the MHRA, but is used in a way that is not described within the medicine's Summary of Product Characteristics (SPC).

22.2 A supplementary prescriber may prescribe medicines for off-label use, but if you decide to do so this must be on the CMP and you should:

- be satisfied that a licensed alternative is not available which includes your proposed usage within its SPC
- be satisfied that there is a sufficient evidence-base for using the medicine in an off-label way to demonstrate safety and efficacy. Where the manufacturer's information is of limited help, the necessary information should be sought from another reliable and reputable source

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

- record the medicine prescribed and the reasons for using an off-label product in the patient's notes
- explain to a patient in broad terms why you are using the medicine in an off-label way
- make a clear, accurate and legible record of your reasons for using a medicine in an off-label manner.

22.3 It is often necessary in paediatric practice to use licensed medicines in off-label ways. You must consult the BNF for Children or other appropriate guidelines before prescribing for children and this must be agreed on the CMP.

Practice Guidance 23: Remote prescribing

23.1 Most prescribing should occur on the basis of a face-to-face consultation with your patient. Remote prescribing occurs if you issue a prescription based on a telephone, e-mail, fax, video-link, web-based or other non face-to-face contact with a patient and would be an exceptional circumstance. You should only remote-prescribe for your own patients or patients on your own case-load with a CMP in place. You must ensure that you have an appropriate dialogue with your patient to:

- establish the patient's current medication history
- carry out an adequate assessment of the patient's condition
- ensure there is sufficient justification to prescribe the medicines remotely, including discussing the feasibility of seeing another prescriber who can carry out a face-to-face consultation. This is particularly important when a remote-consultation does not permit an adequate assessment of the patient's condition to be undertaken
- ensure there are no contraindications to the proposed medicine
- ensure arrangements are in place to provide follow-up and continuity of care
- ensure a clear record is made of the prescribing decision and in particular the method of remote prescribing used eg instruction over the phone, e-mail etc
- ensure that the primary care record holder is informed
- ensure that the patient has "sufficient information" to make an informed choice to accept your recommendation.

23.2 Where you cannot satisfy all of the conditions above, you should not use remote means to supplementary prescribe for your patient.

23.3 Where a medicine (which is listed on the patient's CMP), but has not been prescribed before, you should not prescribe remotely if you have not re assessed the patient.

Practice Guidance 24: Prescribing on the recommendation and/or at the request of others

24.1 You should only prescribe for patients on your own caseload/under your overall care and for whom you have a CMP in place. You must not prescribe for any patients upon whom you have not undertaken an appropriate assessment.

24.2 If you prescribe on the recommendation of another health professional who does not have prescribing rights, you must satisfy yourself that you have a CMP in place, you have performed an appropriate assessment of the patient yourself in order to reach a diagnosis so that you can determine

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

that the prescription request is appropriate for the patient concerned and that the professional is competent to have recommended the medication.

Practice Guidance 25: Controlled drugs

25.1 As a supplementary prescriber working within a written Clinical Management Plan (CMP) you may prescribe any controlled drug listed within the CMP, except those listed in Schedule 1 to the 2001 Regulations which are not intended for medicinal use.

25.2 You must not prescribe a controlled drug for yourself.

25.3 You must not prescribe controlled drugs for someone close to you.

25.4 You must know who your local pharmacist Accountable Officer (AO) is and comply with any local monitoring and/or inspection requests that the AO may make.

25.5 You must follow the Standard Operating Procedures (SOPs) that are in place within your organisation for the usage of CDs according to Regulations and SOPs must include procedures for: prescribing CDs, administering CDs, recording any adverse reactions.

25.6 As a supplementary prescriber you may instruct another person to administer CDs in accordance with your valid prescription and in accordance with national guidance.

25.7 You must ensure that any prescription for a controlled drug is completed on the correct prescription form and contains all the information required commensurate with the Schedule of the controlled drug being prescribed, which will in all cases include the patient's NHS number or other unique identifier.

25.8 You must ensure that:

- in-patient prescribing of CDs is recorded on the Medicines Administration Record (MAR) or in-patient sheet in accordance with local policies
- CDs for patients being discharged are written on locally approved To-Take-Out (TTO) sheets
- out-patient prescribing by supplementary prescribers is on the relevant FP10SS form.

25.9 You must only prescribe CDs at the time of clinical need and you must not prescribe more than is needed for the immediate clinical need, and in any event for no more than a 30 day supply.

25.10 You should note that the validity of prescriptions for Schedule 2, 3 and 4 CDs is 28 days.

25.11 You may use computer-generated prescriptions for controlled drugs, providing the necessary software is in place and that there is an audit trail of your prescribing practice. Your signature must be hand-written. Where patient sticky-labels are used they must be tamper-evident labels and you must sign or initial over the sticky label to indicate that the sticky label relates to the patient for whom your prescription is intended.

25.12 If any part of your prescription for a CD is hand-written, you must write it yourself and not ask any other person to write all or part of the prescription for you.

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

25.13 All private CD prescribers require a separate 6 digit prescriber code for private CD prescriptions (this is different to your unique NHS prescriber code). This ensures that there is a clear separation between NHS and private CD prescribing and if you prescribe in both NHS and private settings you must keep your two prescriber codes separate.

DRAFT

SECTION 3 – MEDICINES GOVERNANCE

These medicines governance arrangements apply to all settings. This covers private practice settings, including where part of your home is your private practice, as well as NHS and other hospital, clinic and occupational health settings. The guidance in this section will apply alongside any organizational policies and/or procedures that the organisation may have in place.

In addition, BDA members are expected to demonstrate that they meet the Single Competency Framework for all prescribers

http://www.npc.co.uk/improving_safety/improving_quality/resources/single_comp_framework.pdf

Practice Guidance 26: Instructions for supplying and/or administration

If you instruct another person to supply and/or administer medicines on your behalf, you must ensure that the individual is educated, trained and competent to do so.

Practice Guidance 27: Dispensing

Dispensing is the preparation and supply of a medicine in accordance with the instructions contained within a prescription. Dispensing is generally performed by a pharmacist or pharmacy technician. You should ensure the separation of prescribing and dispensing of medicines whenever possible. You should not normally dispense against a prescription that you have written.

Practice Guidance 28: Storage

28.1 You should ensure all medicinal products are stored in accordance with the information within the Summary of Product Characteristics / Patient Information Leaflet or information found on the label. Some medicines may require refrigerated storage.

28.2 Medicines can only be stored in "lockable business premises" prior to delivery to the patient. When not in use, medicines should be stored in lockable containers or cabinets or otherwise returned to a pharmacy department for safe-keeping.

28.3 NHS staff: You must not store medicines at home unless you have the written permission of your employer to do this which describes the exceptional circumstances that require you to store medicines in your home, and you must have suitable lockable storage facilities in place.

Home-based Private practice: You must only store medicines in lockable containers that constitute "lockable business premises" which are within the business part of your premises.

28.4 All storage environments must meet the prevailing storage requirements and it is your responsibility to find out what these requirements are. You must ensure correct storage policies are in place and are being adhered to.

28.5 You must not store controlled drugs under any circumstances.

Practice Guidance 29: Transportation

29.1 You may transport medicines from the dispensing pharmacy to their place of use. You must display appropriate health and safety information on your vehicle if the medicine requires it eg medical gases.

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

29.2 You should not leave medicines unattended in your vehicle at any time.

Practice Guidance 30: Disposal

30.1 You must dispose of used, partially used and unused medicines in accordance with current legislation and your local employer policy.

30.2 If there is no local employer policy in place, you must return all medicines to a pharmacist for safe disposal.

Practice Guidance 31: Error reporting

If you discover that you have made an error in prescribing you must take immediate action to prevent potential harm to the patient, and you must report the error as soon as possible according to local protocols.

Practice Guidance 32: Reporting unexpected effects and adverse reactions

32.1 If a patient experiences an adverse reaction to a medication they have been prescribed, you should record this in the patient notes, notify the prescriber (if you did not prescribe the drug) and notify the Medicines and Healthcare Products Regulatory Agency (MHRA) via the Yellow Card Scheme immediately. Yellow cards are found in the back of the British National Formulary and also online at www.yellowcard.gov.uk

32.2 You may also inform the patient that they can report adverse reactions independently to the Yellow Card Scheme.

32.3 You can also report adverse reactions via the MHRA website at www.mhra.gov.uk and serious incidents for investigation (previously known as Serious Untoward Incidents/SUIs) to the National Reporting and Learning Service (which includes National Patient Safety Agency (NPSA) using National Framework for Reporting and Learning from Serious Incidents Requiring Investigation <http://www.nrls.npsa.nhs.uk/home/>). NPSA is now part of NHS England.

Practice Guidance 33: Access to supplies of medicines

33.1 You may obtain the medicines needed for administration to your individually named patient against a valid prescription for the named medicine that is dispensed by a pharmacist.

33.2 You may obtain a stock of medicine ahead of its administration to your patient when you are using a Patient Group Direction (PGD) as long as the legal framework of medicines is used and the named medicine is listed within the PGD.

33.3 You are not permitted to obtain wholesale stocks of medicines to store prior to prescription and/or supply to your patients.

Practice Guidance 34: Complementary, herbal and homeopathic products.

34.1 Complementary, herbal and homeopathic products may interact with other medicinal products and/or laboratory tests. You should ensure that you obtain, and record, information from the patient as to whether they are using any such products. Where there is evidence that you should do so, you may need to advise that your patient stops using a complementary, herbal or homeopathic product prior to starting taking a conventional medicinal product or undergoing a medical and/or surgical procedure.

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

34.2 Some herbal and homeopathic preparations are classed as medicines and are classified as POM, P or GSL depending on their action and route of administration. You may only prescribe and/or supply and administer these products in accordance with a supplementary prescribing and/or supply and administration framework.

34.3 The MHRA regulates other herbal products under the Traditional Herbal Registration (THR) scheme and other homeopathic products under the National Rules Scheme (NRS). Other products may not be subject to regulation of their quality, safety or efficacy. You should only recommend these products if you have suitable education, training and experience to do so.

34.4 The MHRA holds a list of complementary, herbal and homeopathic products that are known to, or may have, interactions with medicinal products and you should be aware of these before recommending that a patient takes a complementary product in addition to, or as a substitute for, any currently prescribed medicine. Some herbal preparations are prohibited or restricted in their use in humans due to known toxic and/or harmful effects, and you must not recommend these products to your patients.

SECTION 4 – CLINICAL GOVERNANCE

Patient safety is of paramount importance within all aspects of prescribing. Dietitians must practise within the law, to a high professional standard, and ensure that they strive continuously to improve the quality of care that they offer to patients. Poor professional performance needs to be identified and rectified at an early stage. The guidance in this section will apply alongside any organisational policies and/or procedures that the organisation may have in place.

Practice Guidance 35: Governance structures

You must follow the governance arrangements that are in place. Arrangements should be in place for:

- clear lines of responsibility and accountability for overall quality of clinical care
- development of quality improvement programmes such as clinical audit, supporting evidence-based practice, implementation of clinical standards, monitoring of clinical care, access to appropriate CPD programmes
- management of risk
- procedures to identify and remedy poor performance
- competency frameworks for prescribing.

Practice Guidance 36: Clinical audit

36.1 Clinical audit is an important part of clinical governance. As a supplementary prescriber, you should audit your prescribing practice.

36.2 As a supplementary prescriber you should ensure that you participate in regular (normally at least annually) meetings with your medical independent prescriber partner.

36.3 You should audit how many of the patients for whom you have prescribed medication have required medical follow-up, and how many have been successfully managed within the dietetic pathway. You should also audit those patients for whom you took an active decision not to prescribe.

36.4 You should monitor how patients respond to treatment and how many follow-up visits are taking place. Systems should be put in place to ensure that patients who do not attend (DNA) for their appointments are followed up (eg by telephone, letter, text message or email).

36.5 As a supplementary prescriber you should audit your practice to ensure that the patient's CMP is being followed.

36.6 You should ensure that the prescriptions you write are clear and legible. You should audit how many times a pharmacist contacts you to query what was written.

36.7 You should seek your patients' experiences of your prescribing where possible.

Practice Guidance 37: Prescribing analysis

37.1 You should ensure that you have information about national guidelines (eg NICE guidelines, NSF documents), local guidelines, local agreements and formularies to ensure you make the best prescribing decision for your patients.

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

37.2 If you are prescribing within the NHS, your activity should be included in the reports on the quality of clinical care to local medicines management committees or their equivalent.

Practice Guidance 38: Learning from incidents and errors

38.1 You should record all incidents and/or errors with your local reporting systems to facilitate national reporting where required.

38.2 You should review incidents within your local team and/or medicines management committee or equivalent, to enable learning and where necessary change practice.

Practice Guidance 39: Risk management

You should ensure that you have an appropriate Risk Management programme in place. This should include clinical risk management and patient safety (including the National Reporting and Learning Service <http://www.nrls.npsa.uk/>), confidentiality, safety of prescription pads and a system for handling errors and complaints.

Practice Guidance 40: Continuing professional development (CPD)

40.1 You must remain up-to-date with appropriate knowledge and skills to enable you to prescribe competently and safely within your scope of practice.

40.2 You should ensure that your prescribing CPD is in line with your current or future practice, including your role as a prescriber.

40.3 You should record your CPD in a format that easily enables you to demonstrate your fitness to practise as a prescriber.

40.4 You should ensure that you set aside sufficient time to access programmes and resources to meet your prescribing CPD needs. This may include Peer Review sessions. You should include reflective learning in your CPD portfolio.

Practice Guidance 41: Poor performance

You should be aware of the procedures in place for identifying poor prescribing practice.

Practice Guidance 42: Safety of NHS prescription pads

42.1 NHS FP10s are classed as secure stationery. Each prescription has a unique serial number, and has specific anti-theft and anti-forgery features. Prescription pads will be ordered by the Trusts via a secure ordering system and supplied to the named professional they relate to. You are responsible for the safety of your named prescription pad. You must take all reasonable and responsible steps to prevent its loss or inappropriate use. You should only use one prescription pad at a time.

42.2 You should keep a record of the first and last serial number of the prescriptions in the pads issued to you. If a whole prescription pad is lost or stolen you must report the serial numbers of the missing prescriptions.

42.3 At the end of each working day you should record the serial number of the first remaining prescription in your current pad. If your current pad is lost or stolen after you last used it, the relevant serial number of unused prescriptions must be reported.

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

42.4 Prescription pads should be stored in locked areas when not in use. You should not store prescription pads away from your place of work. In particular you should not store pads at home or in your vehicle except when travelling between places of work.

Practice Guidance 43: Links with pharmaceutical companies / conflict of interest

43.1 If you have a commercial or financial interest in any pharmaceutical product or company then you should ensure that your interest does not affect your ability to prescribe in the patient's best interest alone.

43.2 You must not allow your own, or your employer's (if applicable) commercial or financial interests in a pharmaceutical company or product influence the way you advise your patients.

43.3 You must declare any conflict of interest in a "register of interests" either within your personal portfolio, or within your employer's Hospitality Register which should be produced on request for audit purposes.

Practice Guidance 44: Gifts and benefits

44.1 Your prescribing choice for your patient must be based solely on clinical suitability and cost effectiveness, working within any local formulary that you may be obliged to follow.

44.2 The advertising and promotion of medicines is strictly regulated. You must not accept personal gifts that are given to influence your prescribing activity nor must you solicit or accept a gift or inducement to influence your prescribing patterns.

44.3 You may accept hospitality for a professional or scientific meeting, but such hospitality should be reasonable in level, and subordinate to, the main purpose of the meeting.

44.4 You may accept awards and/or grants to attend educational events offered by pharmaceutical companies that enable you to undertake CPD relevant to your practice.

44.5 You should follow your employer's policy on receiving gifts and hospitality. If you do not have an employer you should consider whether it is appropriate to accept gifts or hospitality in response to your prescribing activities.

Practice Guidance 45: Checking registrations and annotations

45.1 You must provide evidence of your valid registration as a dietitian with the HCPC to your employer/those using your prescribing services.

45.2 You should provide evidence of your valid status as a supplementary prescriber annually to your employer/those using your prescribing services.

45.3 You must only prescribe in accordance with the supplementary prescribing annotation awarded to you.

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

Glossary

Administration

Process by which a medicine is introduced into, or applied onto, the patient's body.

Advice

The act of giving information to service users pertaining to aspects of the condition for which they are seeking intervention. The information given may be an opinion or recommendation relating to suggested future intervention or actions. The information may include guidance to seek the opinion of another health professional. The information is given to the service user to consider, and the service user may choose whether to act on the advice given or not.

Appropriate practitioner

Registered professional defined within medicines legislation as being authorised to issue prescriptions for POM class medicines and/or to receive bulk supplies of POM class medicines.

Black-triangle drugs

New licensed medicines under intensive monitoring by the MHRA and subject to special adverse incident reporting requirements. The MHRA issues a monthly list of medicines subject to Black Triangle status.

British National Formulary (BNF)

The BNF is a joint publication of the British Medical Association and the Royal Pharmaceutical Society. It is published biannually. The BNF aims to provide prescribers, pharmacists, and other healthcare professionals with sound up-to-date information about the use of medicines. The BNF contains medicines for therapeutic use; it does not include contrast agents which are for diagnostic purposes.

Clinical Governance

Quality assured activities which ensure that pre-determined clinical standards that have been set, are maintained by practitioners, and are evident within health care settings.

Clinical Management Plan (CMP)

A written plan (which may be amended from time to time) relating to the treatment of an individual patient which is agreed by the patient the independent prescriber (a doctor or dentist only) and the supplementary prescriber who is to prescribe, supply and administer (including delegated administration) medicines under the plan.

Licensed medicines including off-label and black triangle products, unlicensed medicines and controlled drugs may be included in a CMP. A CMP may be for a named medicine or a group of medicines eg non-specified NSAIDs.

Commissioner

Person or organisation that requests and/or funds a service or activity.

Competence

The ability of an individual to demonstrate their capability in a certain skill area at a defined level of ability at a set point in time.

Competencies

The component skills that describe and define the actions and activities required in order to demonstrate competence in a skill area.

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

Controlled drug

A medicine subject to control by the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001.

Dietitian

A person who is registered on of the relevant part of the HCPC register under article 5 of the Health Professions Order 2001 and entitled to practise using the protected title of “dietitian/dietician”.

Dispensing

To label from stock. The activities undertaken, in response to formal orders, when medicines are issued to the place where they will be used, or supplied directly to the patient.

Disposal

The removal and disposal of medicines that are no longer required or are no longer suitable for their intended and /or the removal of unwanted medicines or waste materials from the clinical site.

FP10, FP10SS, FP10CD

Types of prescription forms

GSL

General Sales List. A medicine for which all active ingredients are listed in the relevant Human Medicines Regulations schedule, or are so classified in their marketing authorisation.

Guidance

Document containing recommendations for the use of a particular treatment and/or modality, the circumstances when it should be used and the population/patient groups who should receive it. Health professionals have a duty to take guidance fully into account where it is published, but they are not bound by its contents and may deviate from it where there is a clear indication to do so. A guidance document may impose a duty on a health provider to fund the treatment and/or intervention.

Guideline

A wide-ranging recommendation dealing with the management of a disease condition. A guideline document does not impose a duty on a health provider to fund the treatment of the disease condition.

HCPC

Health and Care Professions Council

Independent prescriber (IP)

A professional who is registered on the appropriate statutory register for their professional group and (for non-medical staff) against whose name is recorded an annotation signifying that they are qualified to prescribe, supply and administer medicines as an independent prescriber. A person responsible for the assessment of patients with undiagnosed conditions, and for decisions about the clinical management required including prescribing. They assume full accountability for the prescribing decisions they make. They may instruct another person to administer the medicines under the terms of a PSD. An independent prescriber may be a medical prescriber (doctor/dentist only) or a non-medical independent prescriber (nurse, pharmacist, optometrist, radiographer, and podiatrist). The non-medical independent prescribing professions between them do not have the same rights with regard to the use of mixed medicines, unlicensed medicines, and controlled drugs. Medical prescribers have different rights to all non-medical prescribers together.

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

KSF

Knowledge and Skills Framework

Licensed medicine

A medicine with a valid marketing authorisation (product licence) in the UK.

Marketing authorisation (MA)

Formal approval by the MHRA to place a medicinal product on the UK market, formerly known as “product licence”. It defines the terms, conditions and/or patient groups that the product may be used for. Use of a medicine outside of the terms of the MA is known as “off-label” use of the product.

Medicine administration record (MAR)

Commonly referred to as “drug chart”, MAR serves as a legal record of medicines administered to a patient by a health care professional. The MAR is a part of a patient's permanent record on their medical chart.

Medical device

All products, except medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability. Examples include x-ray and other imaging equipment, pacemakers, artificial joints, anaesthetic equipment, infusion equipment, beds, wheelchairs, and surgical dressings.

Medical prescriber

A doctor or dentist who can independently prescribe both licensed and unlicensed medicines, and who may instruct another health professional to administer such medicines to patients under the terms of a PSD.

Medicinal product

Any substance or article (but not instrument, apparatus or appliance) which is manufactured, sold, supplied, imported or exported, for use wholly or mainly in either or both of the following ways:

- administration to one or more human beings (or animals) for a medicinal purpose
- used as an ingredient, by a practitioner, pharmacy or hospital, in the preparation of a substance or article which is to be administered to one or more human beings for a medicinal purpose

Medicinal purpose

Any one or more of: treating or preventing disease, diagnosing disease or ascertaining the existence, a degree or extent of a physiological condition, contraception, inducing anaesthesia, otherwise preventing or interfering with the normal operation of a physiological function, whether permanently or temporarily, and whether by terminating, reducing, postponing, increasing or accelerating the operation of that function, or in any other way.

Medicine

A substance that claims to, or has the actual function of, treating or preventing disease in humans or animals.

Mixing

The combining of two or more medicinal products together for the purposes of administering them to meet the needs of a particular patient. Mixed medicines are unlicensed.

MHRA

Medicines and Healthcare products Regulatory Agency.

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

NHS

National Health Service

NHS prescription charge

Tax paid by patients for medicines or other treatments prescribed for them by an NHS “appropriate practitioner” and supplied at NHS expense. Some patients are exempt from paying prescription charges and receive the medicines free of charge. Prescription charges are set by the Government and do not directly reflect the production costs and/or retail prices of the medicine.

NICE

National Institute for Health and Care Excellence

Non-medical prescriber (NMP)

A nurse, pharmacist and some allied health professional groups who are registered on the appropriate statutory register for their professional group, and against whose name is recorded an annotation signifying they are permitted by the relevant law to prescribe, supply and administer medicines as either an independent and/or supplementary prescriber. The limits of their prescribing rights is determined by law and may not be the same for each professional group especially with regard to mixing medicines and controlled drugs.

NPSA

National Patient Safety Agency

Off-label drugs

Use of a medicine outside its licensed indications (as contained within the SPC). Off-label use only applies to medicines that are already licensed ie hold a valid Marketing Authorisation.

Over-the-counter (OTC)

Description of a medicine that can be supplied without a written prescription from a variety of outlets, including self-selection without supervision, by a patient.

P

Pharmacy Only

Patient Group Direction (PGD)

A written instruction for the supply or administration of a named medicine in a defined clinical situation to groups of patients who may not have been identified before presenting for treatment. In order to be valid, a PGD must meet specific legal criteria. This includes the requirements that only licensed medicines are included in a PGD, that the health professional (dietitian) named on the PGD is registered with the appropriate statutory regulator (HCPC), and that the supply and administration of the drugs listed in the PGD is not delegated to anyone else. PGDs tend to be used in hospital and primary care settings but are also valid in other non-NHS clinical settings. PGDs can include medicinal products for use outside their licensed indications (“off-label”) if their use is exceptional and justified by best clinical practice. Off-label use only applies to medicines that are already licensed. PGDs cannot be used for the administration of unlicensed products not for the use of pharmacy-prepared products as these are not fully licensed.

Patient Specific Direction (PSD)

A prescription from a doctor, dentist or other independent/supplementary prescriber for a medicine to be administered to a named patient by another health professional. The patient must be individually identified on the PSD. The prescription must be signed and dated by the doctor/dentist or other

**THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT**

independent/ supplementary prescriber. Unlicensed medicines may be administered under a PSD provided it has originated from a doctor or dentist. A PSD is not a standard proforma that is drawn up by a dietitian for a doctor to sign. This may be one way of indicating the desired prescription, but the doctor is free to amend or alter this in any way as they see fit as they will have accountability for any medicines prescribed.

PII

Professional Indemnity Insurance

PIL

The Patient Information Leaflet (PIL) is the leaflet included in the pack with a medicine. It is written for patients and gives information about taking or using a medicine.

Prescribe

LEGAL: to request in writing, in the appropriate manner, the supply and administration of a Prescription Only Medicine for use by a named patient. Only “appropriate practitioners” may prescribe. The Human Medicines Regulations 2012 define the professional groups classed as “appropriate practitioners”.

GENERAL: to authorise in writing, in the appropriate manner, the supply and administration of any medicinal product(s), for use by a named patient, at public expense.

LAY: to advise on the use of a product, especially by an authorised person or to recommend especially as a benefit.

Prescribing

Issuing prescriptions for the medical treatment of a single individual by an “appropriate practitioner”. A pharmacist is legally required to be involved in the sale and/or supply of the medicine identified within a written prescription. Therefore “prescribing” is a process by which medicines are supplied to a patient involving at least two separate persons – the prescriber and the pharmacist.

Prescription

LEGAL: a written instruction by an appropriate practitioner for the supply and administration of the medicinal products listed within it. A written tool against which POM’s may be supplied.

A prescription is issued by an “appropriate practitioner” under or by virtue of the National Health Service Act 1977 (England)/the National Health Service (Scotland) Act 1978 / the Health and Personal Social Services (Northern Ireland) Order 1972.

Prescription Only Medicine (POM)

Such medicines may only be supplied and administered against a valid written “prescription”.

Product Licence (PL)

Formal approval by the MHRA to place a medicinal product on the UK market. Now known as a “marketing authorisation”. Defines the terms, conditions and/or patient groups for which the product may be used. Use of a medicine outside of the terms of the PL is known as “off-label” use of the product.

Repeat prescribing

A partnership between a patient and a prescriber that allows the prescriber to issue duplicate prescriptions at agreed intervals without the patient having to consult the prescriber at each issue.

Repeatable prescription

A prescription which authorises a pharmacist to issue a medicine more than once (eg supply X medicine every month for six months).

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

Standard

A statement on the level of proficiency expected to be demonstrated by a person professing to hold a certain skill or ability. The standards for prescribing are set and regulated by the HCPC.

Standard Operating Procedure (SOP)

Detailed, written instructions to achieve uniformity of the performance of a specific function. SOPs ensure safety and consistency, it is set on repeated application of unchanged processes and procedures and its documentation.

Summary of product characteristics (SPC)

(Previously known as the Data Sheet): Information available for individual licensed medicines, forming an integral part of the marketing authorisation (licence). It provides information for health professionals on how to use the medicinal product safely and effectively.

Supplementary prescriber (SP)

A professional who is registered on the appropriate statutory register for their professional group and against whose name is recorded an annotation signifying that they are qualified to prescribe medicines as a supplementary prescriber. A person responsible for the continuing care of patients who have been clinically diagnosed by an independent prescriber.

Supply

The activities undertaken, in response to formal orders, when medicines are issued to the place where they will be used, or supplied directly to the patient.

Traditional Herbal Registration (THR) number

MHRA registration scheme for herbal preparations that have been assured for safety, efficacy and quality, ie licensing for herbal preparations. Equivalent to a Product Licence for medicines.

To-take-out form (TTO)

The TTO (to take out) is a form that should be completed for all patients being discharged from hospital. It both summarises the patient's hospital stay for their general practitioner and acts as a prescription to order the drugs they need to take home with them

Unlicensed medicine

A medicine that does not have a UK marketing authorisation.

Appendix

Key Legislation and definition of terminology

Medicines use in the UK is controlled by the terms of the Human Medicines Regulations 2012 which provide the legislative framework for medicines use in the UK. Dietitian supplementary prescribers must understand the various medicines frameworks available to them.

Administration framework

The Patient Specific Direction (PSD) – A PSD is a written or electronic instruction from a prescriber for a medicine to be administered to a named patient. It relates to the relationship between the prescriber and another professional. A dietitian must only administer the medicine in accordance with the instructions that are written by the prescriber. Instructions should be written, although in a genuine life threatening emergency an oral instruction may be given.

Supply and administration frameworks

The Patient Group Direction (PGD) – This is not a prescribing tool for the dietitian. A senior doctor and a senior pharmacist, in conjunction with the dietitians who will use the tool, define in writing the named medicines that may be supplied and/or administered to groups of patients who may, or may not, have been individually identified prior to treatment. The PGD must be drawn up in a specific way in order to be legally valid. The dietitian must supply and administer the medicine in accordance with the instructions that are written within the PGD. PGDs are not valid in all healthcare delivery settings.

Exemptions. This is not a prescribing tool. Specific pieces of law allow certain listed medicines to be supplied and administered to patients by certain health professional groups without the need for another appropriate prescribing or supply/administration framework. There are no Exemptions that apply specifically to dietitians.

Prescribing frameworks

Supplementary prescribing. This allows a dietitian to prescribe in partnership with a doctor or dentist, as well as supply and administer medicines to individual named patients. The medicines to be used must be defined in writing within a Clinical Management Plan (CMP) and be appropriate to the needs of the named patient. Supplementary prescribing requires the involvement of a doctor or dentist, the supplementary prescriber and the patient. The terms of use and definition of “Clinical Management Plan” are defined in law. For a CMP to be legally valid, the independent prescriber must be a doctor or a dentist. Supplementary prescribing can be used to prescribe licensed medicines, unlicensed medicines, mixed medicines and all controlled drugs.

Independent prescribing. This allows a prescriber to autonomously prescribe, as well as supply and administer medicines to individual named patients appropriate to the needs of the named patient. The responsibilities of non-medical independent prescribing are different to those for medical prescribing, therefore doctors and non-medical independent prescribers are not directly comparable with each other in their activities. Dietitians are not legally able to practice as independent prescribers

THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE BEFORE IT CAN HAVE EFFECT

Categories of medicine

General Sales List medicines (GSL)

These products can be sold with reasonable safety without the supervision or advice of a doctor or pharmacist, and may be obtained through a variety of outlets. All GSL medicines must hold a valid UK product license and all the active ingredients must be listed in the product. Regulations restrict the pack sizes and quantities of the medicine that may be sold without supervision. Larger volumes may only be sold under supervision (P class) or prescription (POM class). An example of this would be paracetamol that is limited to 16 tablets under GSL terms, but may be supplied in larger quantities under P or POM terms.

Pharmacy sale medicines (P)

These products can be sold with reasonable safety from premises that are under the supervision of a pharmacist but without the need for a written prescription. The products may be available for self-selection by the general public but a pharmacist is aware of the purchase at the point of sale.

Both GSL and P class medicines are known as “over-the-counter” (OTC) medicines as they can be sold and supplied (in some cases only at certain low volumes) without a written prescription for supply.

Prescription only medicines (POM)

The Human Medicines Regulations 2012 define those medicines that must be classed as POM and include those that:

- contain certain listed substances
- are controlled drugs
- are for parenteral (ie injection) administration (with the exception of insulin)
- emit radiation
- come under other listed criteria

POMs may only be sold, supplied and administered in accordance with a written prescription by an appropriate practitioner and dispensed from a registered pharmacy or dispensing doctor's practice.

The Human Medicines Regulations 2012 defines “appropriate practitioner” for the purposes of issuing written prescriptions as:

- doctor, dentist, vet
- independent nurse prescriber
- independent pharmacist prescriber
- independent optometrist prescriber
- independent physiotherapist prescriber
- independent podiatrist prescriber
- supplementary prescriber acting under a written Clinical Management Plan (CMP) - (nurse, pharmacist, midwife, podiatrist, physiotherapist, radiographer, optometrist)

A dietitian who is annotated on the Health and Care Professions Council (HCPC) register as a Supplementary Prescriber may only prescribe POMs under a written Clinical Management Plan (CMP).

***THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT***

The term “Clinical Management Plan” is defined in law by Regulation 215 and Schedule 14 of The Human Medicines Regulations 2012.

Regulations require that POMs may not be advertised to the general public, only marketed to health professionals, and there is blanket ban on the advertising to the public of certain treatments for certain specified medical conditions such as cancer.

Controlled Drugs

The Misuse of Drugs Act 1971 controls certain types of drugs that may be liable to misuse and abuse because of their effects on users. Schedule 2 of this Act lists the drugs subject to these specific controls and it categorises the drugs into one of three classes: Class A, Class B and Class C. The term “controlled drug” is used to refer to drugs within these three categories.

The Misuse of Drugs Regulations 2001 permits the use of controlled drugs in healthcare and further classifies controlled drugs as one of five Schedules that reflect the differing levels of control required for use of each category of drug. Controlled drugs are also subject to specific regulations pertaining to the storage and documentation required for their use.

Dietitians who are annotated on the HCPC register as supplementary prescribers have the right to prescribe controlled drugs in any class, as long as this is included in the clinical management plan.

Acknowledgements

The BDA acknowledges the following documents which were informative in the creation of this guidance for dietitians:

Practice Guidance for Physiotherapist Supplementary and/or Independent Prescribers in the safe use of medicines (2nd edition) (2013). London. Chartered Society of Physiotherapy.

Good Practice in Prescribing and Medicines Management for Podiatrists (2013). London. The College of Podiatry and Institute of Chiropodists and Podiatrists.

Good Medical Practice in Prescribing Medicines (2006). London. General Medical Council.

Standards for Medicines Management (2008). London. Nursing and Midwifery Council.

Standards of Proficiency for Nurse and Midwife Prescribers (2006). London. Nursing and Midwifery Council.

Guidance for Optometrist Prescribers (2009). London. General Optical Council.

**THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT**

Membership of NHS England Allied Health Professionals Medicines Project Board

Representative	Organisation
Lesley-Anne Baxter	Allied Health Professions Federation
Charlotte Beardmore	Society and College of Radiographers
Jan Beattie	Scottish Government
Sarah Billington	Care Quality Commission
Julie Bishop	MHRA
Rebecca Blessing	Department of Health
Sara Bordoley	NHS England
Nicole Casey	Health and Care Professions Council
Bill Davidson	Patient and public representative
Hannah-Rose Douglas	NHS England
Anne Duffy	Department of Health, Social Services & Public Safety (Northern Ireland)
Catherine Duggan	Royal Pharmaceutical Society
Gerry Egan	College of Paramedics
Sue Faulding	Health and Social Care Information Centre
Katherine Gough	Dorset Clinical Commissioning Group
Linda Hindle	Public Health England
Barry Hunt	College of Paramedics (advisory)
Steve Irving	Association of Ambulance Chief Executives
Cathryn James	Association of Ambulance Chief Executives
Elisabeth Jelfs	Council of Deans
Sue Kellie	British Dietetic Association
Helen Marriott (Project Lead)	NHS England
Rowena McNamara	British and Irish Orthoptic Society
Graham Prestwich	Patient and public representative
Suzanne Rastrick (Co-Chair)	NHS England
Patricia Saunders	Health Education England
Alison Strode	Welsh Government
Duncan Stroud	NHS England
Shelagh Morris	NHS England
Bruce Warner (Co-Chair)	NHS England
Hazel Winning	Department of Health, Social Services & Public Safety (Northern Ireland)

**THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE
BEFORE IT CAN HAVE EFFECT**

Membership of Allied Health Professionals Medicines Project Practice & Education Working Group

Representative	Organisation
Jan Beattie	AHP officer, Scotland
Imogen Carter	College of Paramedics
Nicole Casey	The Health and Care Professions Council
Andy Collen	College of Paramedics
Molly Courtenay	University of Surrey
Alison Culkin	St Mark's Hospital, Harrow
David Davis	NHS England
Matt Fitzpatrick	Royal National Orthopaedic Hospital NHS Trust
Jan Flint	Royal Free London NHS Foundation Trust
Christina Freeman	Society of Radiographers
Sarah Griffiths	Bristol Haematology and Oncology Centre
Dianne Hogg	East Lancashire Hospitals NHS Trust
Barry Hunt	College of Paramedics
Hannah Kershaw	The Royal Free Hospital
Jancis Kinsman	Bristol Haematology and Oncology Centre
Judy Love	Society and College of Radiographers
Helen Marriott (Project Lead)	NHS England
Nadia Northway	Glasgow Caledonian University
Najia Qureshi	British Dietetic Association
Anne Ryan	MHRA
Claire Saha	British and Irish Orthoptic Society
Steve Savage	Yeovil District Hospital
Steven Sims	NHS England
Alison Strode	AHP officer, Wales
Pip White	Chartered Society of Physiotherapy

Published: October 2014

Review Date: October 2016

©2014 The British Dietetic Association

5th Floor, Charles House, 148/9 Great Charles Street Queensway, Birmingham B3 3HT

Tel: 0121 200 8080 Fax: 0121 200 8081 email: info@bda.uk.com

www.bda.uk.com

Commercial copying, hiring or lending without the written permission of the BDA is prohibited

