**APPLICATION FOR PRACTICE CERTIFICATE IN INDEPENDENT PRESCRIBING**

**(HCPC Applicants)**

**Institute of Clinical Sciences**

**Practice Certificate in Independent Prescribing**

**Supplementary Programme Application**

**Thank you for applying to the University of Birmingham to join our independent prescribing programme.**

**You are required to complete a supplementary programme application form in order to evidence that:**

* **you meet the Health & Care Professions Council (HCPC) entry requirements**
* **confirm that your Designated Prescribing Practitioner (DPP) satisfies the regulatory requirements**
* **your application is approved by the organisation where you are completing your learning in practice hours.**

**The entry requirements for the programme can be found on the** [**University of Birmingham website**](https://www.birmingham.ac.uk/postgraduate/courses/taught/med/practice-certificate-in-independent-prescribing.aspx#EntryRequirementsTab)**.**

**Please ensure all supporting documentation has been uploaded to the university on-line application portal.**

**If you are employed, this form should be submitted to the employer/trust NMP lead prior to the completing the university application form to ensure appropriate support.**

**Please review the** [Competency Framework for all Prescribers](https://www.rpharms.com/resources/frameworks/prescribers-competency-framework)

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| --- |
| **Sections 1, 2, 3, 4, 5, 7, 11 & 12: to be completed by applicant** |
| **Section 6: to be completed by the Designated Prescribing Practitioner (DPP)** |
| **Section 8: to be completed by employer/referee** |
| **Section 9: to be completed jointly by the applicant and DPP** |
| **Section 10: 10a to be completed by trust or line manager; 10b to be completed by Non-Medical Prescribing Lead; 10c to be completed by applicant if self-employed/budget holder** |

# SECTION 1: PERSONAL DETAILS

# Course Details

**Place of Study:** University of Birmingham

**Start date:** *(please delete accordingly):* January 2024 / March 2024

**Level of study:** 7 (Masters)

**Profession:** *(please delete accordingly):* Podiatrist / Physiotherapist / Paramedic / Therapeutic Radiographer

# Applicant Details

*Please complete in spaces provided*

**Name**

**Job Title**

# Contact details (address)

**Home:**

**Contact Number:**

**Email:**

**Work:**

**Contact Number:**

**Email:**

**Preferred correspondence address:** *(please delete accordingly):* Home / Work

**N.B. All applicants will be required to have a Declaration of Good Character completed and signed by their employer.**

# SECTION 2: NON-ACADEMIC REQUIREMENTS

# Disclosure and Barring Service Check

The programme requires a satisfactory enhanced Disclosure and Barring Service (DBS) in line with filtering rules.

Please see:

<https://www.gov.uk/government/publications/filtering-rules-for-criminal-record-check-certificates>

This must have been carried out within 3 years prior to submitting this application**.**

Please see:

[https://www.birmingham.ac.uk/university/colleges/](https://www.birmingham.ac.uk/university/colleges/professional/external/admissions/dbs/dbs-checks.aspx)

[professional/external/admissions/dbs/dbs-checks.aspx](https://www.birmingham.ac.uk/university/colleges/professional/external/admissions/dbs/dbs-checks.aspx)

**If you already have an enhanced ‘DBS’ (adults and or children) that is acceptable to your employer/placement provider please indicate here *by deleting as applicable.***

Yes / No

Adult / Children

**If yes, please provide a copy of the DBS (this can be a scan) and written confirmation of this on letter headed paper with a signature to include the following information and upload onto the application portal and send a copy to** [**prescribing@contacts.bham.ac.uk**](mailto:prescribing@contacts.bham.ac.uk)

'This is to confirm that ......*please insert name*................. has the following:

- Enhanced Disclosure and Barring Service (DBS) with adult/children/adult and children check *(please confirm which applies)*

- this is acceptable to the employer

*Please complete below.*

**Name:**

**Role within organisation:**

**Have you subscribed to the DBS update service? *Please delete as appropriate***

Yes / No

**If you have subscribed to the DBS update service do you give permission for your DBS status to be checked by the programme? *Please delete as appropriate***

Yes / No

**Please provide your DBS certificate number to allow a check.**

**DBS certificate no:**

**If you do not have a current DBS you will be advised on the DBS process by the admissions department.**

**Do you have anything you wish to disclose in relation to the above? *Please delete as appropriate***

Yes / No

# SECTION 3: PROFESSIONAL ELIGIBILITY

# Professional Eligibility

*Please complete details below*

**Profession:**

**Intended area/scope of clinical practice:**

**No. of years (or equivalent) post qualification experience:**

**No. of years (or equivalent) in the intended area/scope of clinical practice:**

**HCPC Registration number:**

**Expiry Date:**

**Professional Body registration number:**

**Expiry Date:**

# SECTION 4: QUALIFICATIONS & PROFESSIONAL INDEMNITY

# Requirements for Prescribing

**Your educational and professional qualifications are included in the university on-line application.**

# Please provide and supporting information below (additional qualifications, professional experience likely to facilitate prescribing)

Confirmation of professional indemnity insurance (*please delete as appropriate)*

Yes / No

Have you registered/ commenced/partially completed a prescribing course previously?

*(please delete as appropriate)*

Yes / No

**\*If yes please give reasons for NOT completing the course**

**Please provide evidence of your ability to study at level 7:**

# SECTION 5: READINESS FOR PRESCRIBING ROLE

Have you completed a health/clinical assessment course (or specialist equivalent)?

*(please delete as appropriate)*

Yes / No

If YES, please give details of course attended and ensure section below is completed and signed by a professional colleague.

Course attended: Date completed:

If NO have you been deemed competent by an appropriate professional colleague, in clinical/health assessment, diagnostics/care management and planning and evaluation of care prior to being put forward for this course?

Please give details and ensure section below is completed and signed.

**I confirm that the applicant is competent in clinical/health assessment, diagnostics/care management and planning and evaluation of care, and is a suitable candidate for prescribing.**

(NB this may be achieved by internal assessment of competence or completion of an appropriate health/clinical assessment course)

**Name:**

**Title/ position:**

**Signature:**

**Qualification:**

**Please provide reasons for your application for a prescribing course**

**How will your ability to prescribe maximise benefit to the patient? (role/service delivery benefit, expected changes to clinical pathway, timeliness of provision, effectiveness, impact on patient journey/experience, improve access to medicines)**

**How will your ability to prescribe benefit your organisation? (service improvements, financial improvements, skills utilisation, capacity improvements)**

**Please provide details of the service you intend to prescribe in:**

# SECTION 6: DESIGNATED PRESCRIBING PRACTITIONER (DPP)

**Eligibility criteria for becoming a Designated Prescribing Practitioner (DPP)**

**Further information for DPPs is available in** [**Designated Prescribing Practitioner Competency Framework**](https://www.rpharms.com/resources/frameworks/designated-prescribing-practitioner-competency-framework)

# Agreement by DPP for Supervision of Applicant

**Name of DPP:**

**Profession:**

**Professional registration no:**

**Speciality:**

**Work address:**

**Telephone number:**

**Email address:**

***For the following questions, please delete as appropriate.***

**1. I am registered healthcare professional in Great Britain or Northern Ireland with active legal prescribing rights. Yes/No**

**2. I have at least 3 years recent and frequent prescribing experience in a patient-facing role in the trainee independent prescribers intended area(s) of prescribing. Yes/No**

**3. I am in good standing with my profession’s regulatory body. Yes/No**

**4. I have received equality and diversity training and/or an equality and diversity update within the previous 12 months. Yes/No**

**5. I have appropriate patient-facing clinical and diagnostic skills. Yes/No**

**6. I have the ability to assess patient-facing clinical and diagnostic skills. Yes/No**

**7. I confirm that I have reviewed the Designated Prescribing Practitioner Competency Framework and that I meet the competencies in the framework. Yes/No**

**8. I confirm that I have indemnity insurance to support clinical supervision. Yes/No**

**Please outline below your experience of teaching, supervision, and assessment of healthcare professionals, including details of any formal qualifications you may have in this area.**

**Please provide evidence below to demonstrate recent (over the previous year) CPD or revalidation relevant to this role.**

**I confirm that I have agreed to supervise, support and assess the applicant for a minimum of 90 hours in their prescribing role during clinical practice and the information provided within this section is true and correct.**

**Signature of DPP:**

**Date:**

# SECTION 7: EVIDENCE OF CONTINUING PROFESSIONAL DEVELOPMENT (CPD) AND NETWORKS OF SUPPORT

**Please provide evidence to demonstrate that you reflect on your own performance and take responsibility for your own CPD. This should include examples of types of activity, development and assessment that demonstrate reflection on performance and practice.**

**Provide at least 4 examples of your CPD over the previous year prior to application**

***Please use more room by spacing down if you need to.***

**Networks of Support**

**Please provide details/evidence to demonstrate how you will develop your own networks for support, reflection and learning as a prescriber, including prescribers from other professions.**

# SECTION 8: EMPLOYER TESTIMONIAL/REFERENCE

# Testimonial/s to Support Experience

Evidence of appropriate experience required can be further supported by written testimonials from your current / sponsoring / or most recent employer. The form below should be completed by the referee. If you are self-employed or work for more than one employer, please seek at least one testimonial. Alternatively additional comments can be attached to this application on official headed letter.

**Referee’s name:**

**Referee’s job title/role:**

**Referee’s profession:**

**Reference for NAME:**

**I confirm that the applicant has at least 3 years post-qualification experience in the clinical setting in which they will be prescribing and is registered with the HCPC. *Please delete as appropriate***

**Yes / No**

**If the applicant is self-employed please comment on how long they have been known to you and include dates and details of when they worked for you.**

**I also confirm that the applicant manages their own CPD and develops networks for support, reflection and learning (*Please delete as appropriate)***

**Yes / No**

**Referee’s additional comments in support of prescribing application:**

**Referee’s signature:**

**Date:**

# SECTION 9: IDENTIFIED AREAS FOR DEVELOPMENT OF CLINICAL AND DIAGNOSTIC SKILLS

**Discuss the following with your DPP before completing:**

**Development of Clinical and Diagnostic Skills**

Name of trainee independent prescriber (TIP) :

**At the end of the course your DPP must provide confirmation that you are clinically competent in the area(s) for which you intend to prescribe when you qualify as an independent prescriber. This includes clinical assessment of patients, the ability to use basic diagnostic aids and make an assessment of the patient’s general health.**

**Consider the clinical and diagnostic skills in which to develop competence and the use of specific diagnostic aids or equipment required to diagnose and monitor response to therapy. Discuss and agree a proposed plan of action to achieve these under the supervision of the DPP. This will inform your initial learning contract. Please ensure it is signed by your DPP.**

Clinical and diagnostic skills in which to develop competence: *(please bullet point by number if needed Please use more room by spacing down if you need to)*

Proposed plan of action under the supervision of the DPP*(please bullet point by number if needed Please use more room by spacing down if you need to)*

**DPP name:**

**DPP signature:**

**Date:**

# SECTION 10: APPROVAL (IF EMPLOYED BY NHS TRUST)/CONFIRMATION IF SELF-EMPLOYED

# 10a Trust Approval-Line Manager Confirmation

Please delete as appropriate

1. Agreement for the applicant to be released for a minimum of 6 mandatory study days, 2 assessment days (and any resits) and an additional 90 hours learning in practice.

**Yes / No**

1. The applicant has appropriate supervision and support

**Yes / No**

1. The area of prescribing activity is linked to core service provision

**Yes / No**

*NB. If the service is time limited or a pilot/service please give details below:*

1. On qualification the applicant will have access to a prescribing budget and other practical requirements for prescribing.

**Yes / No**

1. On qualification the on-going CPD requirements of the prescriber will be supported

**Yes / No**

1. I confirm that non-medical prescribing is included in the applicants Job description or a letter of empowerment to prescribe within the Trust will be appended to the job description

**Yes / No**

**Name :**

**Job Title :**

**Work address:**

**Telephone number:**

**E-mail address:**

**Signature:**

**Date:**

# 10b Trust/Employer Approval - Agreement by Non-medical Prescribing Lead or person of equivalent responsibility for governance of non–medical prescribing.

Non-medical prescribing lead agreement to DPP that there will be access to a prescribing budget and a benefit to patient services by training this nominee

**Name :**

**Job Title :**

**Work address:**

**Telephone number:**

**E-mail address:**

**Signature:**

**Date:**

# 10c Self – Employed Applicant Responsible Person confirmation

For self-employed practitioners, please liaise with the Programme Director to ensure an appropriate Responsible Person is selected prior to submission of the application.

This is to confirm that I have discussed the requirements below with the applicant and I am satisfied that they understand and will comply with the requirements (please delete as appropriate)**:**

1. Agreement for the applicant to be released for a minimum of 1 mandatory induction day, 6 mandatory study days, 2 assessment days (and any resits) and an additional 90 hours learning in practice.

**Yes / No**

1. The applicant has arranged for appropriate supervision and support.

**Yes / No**

1. The applicant has provided evidence that the area of prescribing activity is linked to core service provision in the applicants current self-employed role.

**Yes / No**

*NB. If the service is time limited or a pilot/service please give details below:*

1. On qualification the applicant will have access to a prescribing budget and other practical requirements for prescribing

**Yes / No**

1. On qualification the applicant will ensure CPD requirements are maintained.

**Yes / No**

1. I confirm that applicant is aware that non-medical prescribing is required to be included in their job description (JD) or a letter of empowerment to prescribe must be appended to their JD

**Yes / No**

The applicant confirms that policies/procedures and clinical governance infrastructure and professional indemnification processes are in place to support non-medical prescribing

**Name :**

**Job Title :**

**Work address:**

**Responsible Person Profession And Registration Number (as applicable):**

**Telephone number:**

**E-mail address:**

**Signature:**

**Date:**

# SECTION 11: FUNDING

**Please give details of funding source for this course:**

***Please delete as appropriate***

Funding will be allocated by means of Learning Beyond registration process within the Trust/organisation/Funding is allocated by NHSE /Other (please specify)

**Budget Holders signature:**

**Budget Holder code:**

# SECTION 12: APPLICANT AGREEMENT

* I agree to communication between my employer, NMP lead for my Trust/Organisation and the University I am attending to discuss any aspect of my attendance and progress on the prescribing course.
* I agree to undertake Continuing Professional Development on completion of this course
* I have read and understood ‘Appendix 1’
* I have read the entry criteria as set by the HCPC for this course and fulfil those requirements.

**Additionally (please delete the statement that is not applicable):**

* I confirm that I have appropriate numeracy skills to undertake this course or
* I recognise that my numeracy skills require updating and will undertake appropriate study to ensure that they meet the required standards prior to undertaking the prescribing course.

**Signature:**

**Name:**

**Date:**

Appendix 1

**Please see relevant section for conditions on signing Prescribing applications**

Applicant

**- Will attend all course dates at University as required**

**- Prior to starting course has met with Designated Prescribing Practitioner (DPP), and discussed learning objectives and methods for supervision**

**- Attend all supervisory sessions with DPP as required.**

**- Complete requirements of course within allocated time period**

**- If the candidate interrupts their studies for independent prescribing, the programme must be completed within the requirements of your registering body and the regulations of the University**

**- If assessments are not completed within 2 years from the start, the candidate must undertake the entire programme again including all the assessments to maintain currency.**

**- Once qualified, informs line manager and lead for non-medical prescribing immediately**

**- Intends to prescribe within area of work and competence once qualified**

**- Participates in regular in-house and/or external CPD support mechanisms once qualified**

**- Provides honest and constructive feedback on the course to manager and programme lead for prescribing within the higher education institution**

**- Mentors and supports colleagues undertaking the course at a later date**

**- Participates in local steering group and work to develop supporting policies**

**- Candidates should be aware of national and local policies in relation to prescribing**

Line Manager

- Agrees the appropriateness and suitability of candidate application and ensures the candidate is able to apply the prescribing principles to their area of practice

- Understands and accepts the requirements for candidate attendance at University and with DPPs

- Agrees with choice of DPP who is suitably experienced and qualified to undertake this role effectively and have attended the local HEI training course to equip them for this role.

- Confirms Trust policies/procedures and clinical governance infrastructure and professional indemnification processes are in place to support non-medical prescribing

- Effective policies for record keeping must be in place to ensure records are accurate, comprehensive, contemporaneous and accessible by all members of a prescribing team.

- Evaluates experiences of candidates and provides feedback to the programme lead within the HEI

- Provides opportunity for CPD

- All registrants must record their prescribing qualification. Individuals have a duty to comply with their registering bodies regulations

**Non-medical Prescribing Lead**

- Confirms trust policies/procedures and clinical governance infrastructure and/or professional indemnification processes are in place to support non-medical prescribing

- Agrees appropriateness of candidate selection and is involved in selection process.

- Agrees that the DPP is appropriate

- Maintains database of all prescribers

- Represents trust at meetings such as regional Non-Medical Prescribing Groups

- Knows the content of curriculum and attends University curriculum group meetings to feedback evaluation, concerns, etc.

- Is available for candidate one-to-one support

**Designated Prescribing Practitioner**

- Confirms that they have relevant experience and qualifications to assess and supervise trainee independent prescriber within the clinical area to enable them to fulfil the clinical competences required for the completion of the prescribing course.

- Knows the content of the curriculum and expectations of students

- Knows where and how to raise concerns about students conduct, competence and achievement

- Has attended a training session/undertaken an on-line training update session to enable effective support for in the clinical area

- Makes assessment decisions informed by feedback from other health care professionals that the trainee independent prescriber may have gained experience with during their clinical supervision

- Maintains current knowledge and expertise relevant for the competencies and programme outcomes that they are assessing

- Confirm that they will continue to proactively develop their professional practice and knowledge in order to fulfil their role

Conflicts of Interest

A conflict of interest is “a situation that has the potential to undermine the impartiality and objectivity of decision making within the application process or during the course. Conflicts of interest can arise when an individual’s judgement is influenced subjectively through association with colleagues out of loyalty to the relationship they have, rather than through an objective process. Conflicts of interest can occur because of personal or commercial relationships

The Designated Prescribing Practitioner must be sufficiently impartial to the outcome for the and should not be the same individual as the person sponsoring the trainee independent prescriber to undertake the programme, nor should they be related to the applicant.

The Responsible Person should also be objective in their confirmation and must therefore discuss with the applicant if they cannot provide confirmation of their suitability to undertake the course objectively.

Failure to declare conflict of interest with DPP will involve contacting professional regulatory bodies and delay in obtaining qualification or potential removal from programme.

**APPLICATION FORM CHECKLIST**

**CHECK THAT YOU HAVE:**

* Referred to the checklist on the [website](https://www.birmingham.ac.uk/postgraduate/courses/taught/med/practice-certificate-in-independent-prescribing.aspx).
* Read and understood the information in the Appendix 1.
* Ensured all relevant sections are signed by your line manager and non-medical prescribing lead.
* Signed and dated the applicant agreement.

Failure to include correctly completed documentation may result in delays in the application procedure.

For office use only (Trust/Employer/Self-employed)

Approved for attendance on the course: Yes / No

Signature: Date: