

Webinar 3: Competence, Scope & Clinical Risk

CPGM

ALLIED HEALTH TRAINING

Prescribing safely within scope across Pharmacy First, contraception and prescription management.

Programme background and purpose

From Autumn 2026, the NHS Community Pharmacy Prescribing Service becomes part of the CPCF.

National reform

October 2026

The Community Pharmacy Prescribing Service formally joins the CPCF, expanding Pharmacy First and the Pharmacy Contraception Service, and adding new clinical pathways.

New workforce

Summer 2026

Newly qualified MPharm graduates can register directly as Independent Prescribers.

More pharmacists are qualifying as Independent Prescribers.

Aims of the programme

To support contractor readiness to deliver Community Pharmacy Prescribing Services through:

- **Delivering a series of six webinars, led by CPGM, CPPB and Allied Health in partnership with the GM ICB.**
- **Developing a Community Pharmacy Prescribing Services Operational Readiness Toolkit and Quick Start Guide to help contractors prepare for the safe delivery of Community Pharmacy Prescribing Services (coming soon).**
- **Providing guidance, references and key actions to be completed to prepare for ICB assurance processes, based on national guidance and supporting documentation.**

Community Pharmacy Prescribing Services Operational Readiness Webinar Series

A series of live webinars supporting contractor readiness.

Webinar 1	Mon 2 Nov 2026	Community Pharmacy Prescribing Services – GM Governance Arrangements	Completed – slides and recording have been shared
Webinar 2	Tue 10 Nov 2026	Clinical Governance, Statutory Duties & Prescriber Workforce Assurance	Completed – slides and recording to be shared
Webinar 3	Tue 17 Nov 2026	Prescriber Competence, Scope of Practice & Clinical Risk Management	Live registration link
Webinar 4	Tue 24 Nov 2026	Digital Prescribing Systems, EPS, Smartcards & Information Governance	Live registration link
Webinar 5	30th Nov 2026	Operational Go-Live, SOPs, Audit & Incident Management	Live registration link
Webinar 6	Tue 8 Dec 2026	GM Care Record	Link to be provided

Community Pharmacy Greater Manchester

Future support

Support will continue to develop in line with contractor needs.

Webinars and training

Future webinars and training offers will be developed based on contractor needs and training requirements.

Please book onto the training now. Your feedback and participation will help us to develop the right support for you.

Clinical leadership

Working with GM ICB, clinical leadership support is being considered for contractors and Community Pharmacy prescribers.

Key messages

- Take your time to read and understand the requirements.
- The information provided will help you make an informed decision about whether you want to deliver the service.
- The guidance is intended to support you to work through the preparation over time – you don't have to do all the actions straight away.

Community Pharmacy Greater Manchester

Our planned support

Planned support to help contractors and prescribers prepare to deliver the service.

Dedicated drop-in sessions

Dedicated drop-in sessions for contractors and prescribers to ask questions and get support as they prepare to deliver the service.

Focus on IP briefings

Briefings focused on Independent Prescribers (IPs), covering what the service means for prescribers working in community pharmacy.

CPGM website page

A dedicated Independent Prescribing page on the CPGM website:

greatermanchester.communitypharmacy.org.uk/national-services/independent-prescribing/

Clinical training sessions

Clinical training sessions to help prescribers build the knowledge and skills needed to deliver the service safely.

IP Forum

A forum for Independent Prescribers to share learning, discuss practice and support one another.

Follow-up webinar

A follow-up webinar to consolidate learning and reinforce the key points from the webinar series.

Purpose and practical outcomes

Purpose: help NHS PCPs and contractors define, evidence and grow scope, and manage clinical risk.

Define and evidence scope

Use the RCPharm Competency Framework, a portfolio and an annual scope declaration to show each prescriber is fit for purpose.

Grow scope safely

Put development plans, supervision and a clinical risk assessment in place before scope expands, including for newly qualified prescribers.

Prescribe within the rules

Apply the Pharmacy First, contraception and prescription management guidance, including exclusions and face-to-face rules.

Manage clinical risk

Embed consent, record access, safety-netting, safeguarding, antimicrobial stewardship and best value in every consultation.



By the end: know what each NHS PCP can safely prescribe today, and what evidence proves it.

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Webinar 3 scope and the sessions ahead

Webinar 2 set the duties and assurance model. Today covers how prescribers practise safely within it.

In scope today

Scope of practice and the scope declaration

Development plans and supervision

Pharmacy First, contraception and prescription management

Clinical risk and remote consultations

Two case studies on evidencing competence

Recap and the sessions ahead

Webinar 2: Clinical governance & workforce assurance

Legal foundation, onboarding, Professional Assurance Framework checks, supervision and appraisal. Today builds on these.

Webinar 4: Digital systems, EPS & information governance

System procurement, cost centres and prescriber codes, smartcards and EPS. GP messages, records, confidentiality, retention and MYS payments.

Webinar 5: Go-live, SOPs, audit & incidents

Toolkit and readiness checklist, SOPs, premises and service delivery. Incident learning, audit evidence, claims verification and suspension or withdrawal.

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Webinar structure

1. Scope and competence

RCPharm framework, portfolio and the annual scope declaration

2. Growing scope

Development plans, supervision, PGDs first and the PEPP

3. Pharmacy First

Seven existing and five prescriber-only pathways

4. Contraception

Prescribing within the Pharmacy Contraception Service

5. Prescription management

Permitted scenarios, exclusions and informing the prescriber

6. Clinical risk and remote care

Consent, records, safeguarding, AMS, best value and video

Key sources for today

Assurance Framework

Employer and prescriber duties: fitness for purpose and scope declarations, supervision and appraisal.

Prescribing guidance

Clinical Prescribing Guidance and the Prescription Management Guidance.

The specification

Permitted activity, competence, consent, record access, remote rules and governance.

Service specifications

Pharmacy First and Pharmacy Contraception: requirements, consent and consultation modes.



Also: RCPharm Competency Framework for all Prescribers; GPhC In practice: Guidance for pharmacist prescribers

Is every prescriber's scope written down and evidenced?

Choose one option that best reflects your pharmacy right now and add to the meeting chat.

A Yes: scope is written and evidenced

B Partly: written, but evidence is patchy

C Unsure what a scope declaration should contain

D Not started yet

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Fit for purpose: what the Professional Assurance Framework expects

Two different tests

GPhC registration shows fitness to practise. The framework also asks for fitness for purpose: safe and competent for this service, in this setting.

The employer must

Confirm the IP annotation and indemnity, record each prescriber's declaration of fitness for purpose including scope, and keep the checks for at least 5 years.



The prescriber should

Self-assess annually against the RCPharm framework, keep a portfolio, revalidation, complete relevant CPD and peer discussion, and prescribe only within scope.

Ongoing review

A prescribing appraisal with the clinical supervisor at least annually, and an updated declaration whenever scope changes.

Source: Professional Assurance Framework, sections 2.4.2, 2.4.4 and 2.5.1

Evidencing scope with the RCPharm Competency Framework



The consultation: competencies 1 to 6

Assess; identify evidence-based options; reach a shared decision; prescribe; provide information; monitor and review.

Prescribing governance: competencies 7 to 10

Prescribe safely; prescribe professionally; improve prescribing practice; prescribe as part of a team.

Portfolio evidence that counts

Decisions (including not to prescribe), peer discussion, feedback, observations, reflections, errors, logs, audits and CPD.

Sources: RCPharm Competency Framework for all Prescribers; Professional Assurance Framework 2.5.1

The annual scope declaration: what to include



Services and pathways

Which Pharmacy First pathways, contraception methods and prescription management scenarios you will prescribe for.

Patient groups

Age ranges and groups covered, such as children, pregnancy and breastfeeding, and those you will refer.

Skills and equipment

Examinations and equipment you are competent to use, such as an otoscope or a BP monitor.

Limits and referral

What is outside your scope today, and where those patients go instead.

Evidence and sign-off

Portfolio references, the supervisor discussion and the date the employer recorded it.

Review triggers

Update at least annually, and whenever scope changes or you stop prescribing.

Suggested structure based on the PAF declaration of fitness for purpose, including scope (2.4.2)

Activity 1: Map a scope declaration



Priya's draft declaration

Priya is an NHS PCP with three years in general practice.

Her draft scope says only: "Pharmacy First and contraception."

She has never used an otoscope and has not managed acne.

Decide

Is the draft fit for purpose? If not, why not?

Rewrite

Name two pathways in scope, one gap, and the evidence needed.

Report

Post: in scope / gap / evidence / plan.

Learning outcome: a declaration names pathways, patient groups and limits, backed by evidence.

More detail: Webinar 5 (audit and appraisal evidence)

Expanding scope: plan first, prescribe second

Development support and a clinical risk assessment come before any expansion of prescribing scope.



Identify the gap

Self-assess against the RCPharm framework for the new pathway or method.

Risk assess

The employer completes a clinical risk assessment before scope expands.

Development plan

A structured plan, using RCPharm guidance on expanding prescribing scope.

Supervised practice

Named supervisor or mentor, protected time and case review.

Declare and review

Update the declaration and review at the next prescribing appraisal.

Employers must not ask prescribers to expand scope without development support and a clinical risk assessment. NHS PCPs need a clear development plan for any pathway they are not yet competent to provide.

Sources: Professional Assurance Framework 2.4.4 and 2.5.1; Prescribing Specification 5.3

Supervision is expected: the Professional Assurance Framework

Named supervisor

Employers should ensure that “prescribing pharmacists have regular access to a named clinical supervisor or prescribing mentor, for example, one supervision session per month”.

Prescribing appraisal

Employers should ensure that “time is allocated regularly, and at least annually, to complete a review of prescribing practice (prescribing appraisal) between the pharmacist prescriber and their clinical supervisor”.



Scope needs support

Employers should ensure that pharmacists “are not asked to expand their scope of practice (including prescribing) without appropriate development support and clinical risk-assessment”.

The prescriber’s duty

Prescribers should “complete a prescribing appraisal at least annually with their clinical supervisor”, considering “whether additional clinical supervision sessions are required if a change in the service is planned”.

Quoted from the Professional Assurance Framework: section 2.4.4 (employers) and section 2.5.1 (prescribers)

Guidance: Example of what supervision could look like



Three types

Clinic/practice (day to day), clinical/professional (regular, named senior clinician) and educational.

What it covers

Reviewing performance, cases and incidents; evidencing competence and CPD; a development plan.

How often

Monthly recommended for clinical pharmacists; sessions of at least an hour; daily debrief where risk is high.

Make it work

Protected regular time, a written supervision agreement, recorded sessions and trained supervisors.

Why it matters

Keeps staff within scope and competence, supports CPD and revalidation, and reduces isolation.

Peer and group

Group sessions and peer support supplement, but do not replace, a named supervisor.

Referenced by the PAF as a guide to clinical supervision. Not specific to community pharmacy, and not contractual.

Newly qualified prescribers: a supported start

PGDs first

Contractors may ask newly qualified pharmacists to use PGDs while they build competence.

Then onboard

Once competent, onboard as an NHS PCP. NHS PCPs prescribe and cannot use these PGDs.

Pharmacist Enhanced Practice Pathway

Encourage newly qualified prescribers to enrol for supervised development.

Structured support

Development plan, induction and mentorship; a reference from their DPP or DMP.



Sources: Prescribing Specification 4.3, 4.4, 5.4 and 5.6; Professional Assurance Framework 2.4.4 and 4.1

Case study: demonstrating competence in the IP pathfinder



1. Area identified

Respiratory, minor illness and hypertension, with training in each.

2. Mentor observation

A clinical mentor observed real consultations.

3. Real-time support

A Teams channel with the local surgery for live queries.

4. Portfolio

Cases, learning and reflection written up in the portfolio.

5. Written testimonial

The mentor's written account of observed practice.

6. Clinical audit

An audit of a sample of consultations against standards.

Trained, observed, supported, recorded, endorsed and audited: the same route works for any new area of scope.

Scenario 1: “Can Amir start acne consultations tomorrow?”

Case study 1 of 3 · Scope and newly qualified prescribers ·

The scenario

Amir joined the register as an independent prescriber in September 2026.

The contractor onboarded him as an NHS PCP straight away so the pharmacy could “use prescribing”.

He is confident with UTI and sore throat however has never managed acne or used an otoscope.

Tomorrow a teenager with acne and a child with earache are booked in.



What is the safest position for tomorrow?

A Amir sees both. He is annotated and onboarded and can read the guidance tonight.

B Amir sees the acne patient and uses the PGD for the child’s earache.

C Amir sees only patients within his evidenced scope. The others go to a competent NHS PCP or are referred, and a development plan starts.

D Amir sees both, and a colleague checks his notes afterwards.

Choose A, B, C or D.

Discuss in chat: how do you confirm a prescriber is competent for each pathway, not just onboarded?

More detail: Webinar 5 (audit and appraisal evidence)

Scenario 1: debrief

Answer: C

NHS PCPs prescribe only within their scope and competence. An onboarded NHS PCP cannot fall back on PGDs, so patients outside Amir's scope need another competent NHS PCP or a referral.



Why A, B and D are incorrect

- Onboarding is not competence for every pathway
- An NHS PCP cannot use the PGD for these consultations
- Reading guidance is not supervised practice
- Checking notes afterwards does not make the decision safe



What should happen

- Agree a declaration listing what Amir can do now
- Development plan for acne and otitis media
- Named supervisor and supervised cases
- Consider PGDs before onboarding next time
- Encourage PEPP enrolment



Evidence to hold

- Signed scope declaration
- Development plan and supervision log
- Otoscope training and competence sign-off
- Clinical risk assessment for the change
- Referral route to another NHS PCP

Ask "is this prescriber competent for this pathway?", not "is this prescriber onboarded?"

Sources: Prescribing Specification 3.16, 4.3, 5.3, 5.4 and 8.5; Professional Assurance Framework 2.4.4

Pharmacy First: 7 existing and 5 prescriber-only pathways

NHS PCPs deliver the clinical pathways by prescribing, within their competence and the Clinical Prescribing Guidance.

Pathways	PGD route	NHS PCP
Existing Pharmacy First: 7 pathways UTI, acute otitis media, sinusitis, sore throat, impetigo, insect bites, shingles	Non-PCP pharmacists only Within PGD criteria	**Prescribing only**
Prescriber-only: 5 pathways Acne (12+), otitis externa (18+), migraine (18+), skin infections (12+) and scabies (1+), allergic rhinitis (3 to 11)	**No PGD route**	**Prescribing only**
Minor illness and urgent medicines supply	Existing service routes	**Prescribing prohibited**

Prescribing can go beyond PGD limits where the guidance allows, e.g. patients excluded from a PGD solely on age, with safety-netting.

Follow guidance exclusions unless a clinical reason is clearly documented

Sources: Prescribing Specification 4.2 to 4.8; Clinical Prescribing Guidance 1.6, 2.10 and Appendices A and B

How the Clinical Prescribing Guidance works



MAY be appropriate

Where prescribing beyond the PGD can be considered.

MAY NOT be appropriate

Not expected: the action and urgency, usually referral.

Exceptions

Exceptional, justified, documented, within the pathway.

Urgent referral

Sepsis, severe infection or red flags: refer urgently.

Licensing

No unlicensed medicines; off-label only if supported.

Tools and records

Use the GP record, PMR and equipment; record reasoning.

Source: NHS Community Pharmacy Clinical Prescribing Guidance, sections 2.5 to 2.16 and Appendix A

Prescriber-only pathways: key boundaries



Acne (12+)

Topical only. Acne fulminans or suicidal thoughts: urgent referral.

Otitis externa (18+)

Exclude perforation or grommet. Suspected malignant otitis externa: A&E.

Episodic migraine (18+)

Screen red flags. No triptans in cardiovascular or cerebrovascular disease. Pregnancy: refer.

Skin infections (12+)

Sepsis, necrotising fasciitis, facial or genital infection, or suspected DVT: urgent referral.

Scabies (1+)

Refer under 1s, crusted scabies and care-home outbreaks. Contacts: own consultations.

Allergic rhinitis (3 to 11)

Asthma not controlled: refer. Maximum two prescriptions a season.

Source: Clinical Prescribing Guidance, Appendix B. Always check the full MAY / MAY NOT tables.

Prescribing within the Pharmacy Contraception Service

In scope

Initiation, ongoing supply, re-initiation, switching and oral emergency contraception.

Not in scope

Implants, IUDs, and prescribing only for a non-contraceptive reason.

Beyond the PGDs

Injectable LARC depends on local arrangements.

Patch, ring and depot injection.

Refer when

Multiple UKMEC 2 or any UKMEC 3/4, under 16 and not Fraser competent, or unexplained bleeding.



Sources: Prescribing Specification 4.9 to 4.12; Clinical Prescribing Guidance, Appendix C

Contraception consultations: safe practice



UKMEC and medicines

Use UKMEC for every method. Check interactions, and for teratogenic medicines recommend highly effective contraception.

Blood pressure and BMI

Record using validated equipment. Measurements supplied by the person can be accepted where clinically appropriate.

Consent and GP notification

Seek consent to notify the GP. If declined, or the person has no GP, the consultation can proceed without notification.

Sources: Prescribing Specification 4.14 and 6.5; Clinical Prescribing Guidance, Appendix C; PCS specification

Prescription management: when it can be used

Four conditions, all required

Routine dispensing cannot fix it; it is clinically appropriate and, in the patient's best interests; the patient consents; governance is agreed with the prescriber.

Inclusion circumstances

Medicine unavailable, prescribing error, omitted medicine, medicine no longer required, quantity synchronisation, or ICB/PCN-led optimisation.

Your own prescription

You do not amend another prescriber's prescription. You assess independently, issue your own, and take full responsibility.

Discretionary and unpaid

Use it where it is in the patient's best interests. No fee is payable, and the replaced EPS item is marked not dispensed.



Sources: Prescription Management Guidance, sections 1 to 2 and 5; Prescribing Specification 4.22 to 4.28

Prescription management: permitted scenarios

Always inform the originating prescriber and consult them first where the guidance requires it.

Scenario	Example	Permitted action
Unavailable: same medicine	Ramipril 5 mg capsules out; tablets in stock	Prescribe the equivalent strength or formulation, after SSPs
Unavailable: alternative needed	Prolonged national shortage	Alternative only with prior agreement or prescriber discussion
Prescription error	Wrong strength, form, quantity or directions	Correct via the agreed local process, or prescribe
Omitted medicine	A repeat item missing, treatment interrupted	Confirm it was not intended, then prescribe
No longer required	Duplicate therapy or a stopped medicine	Do not supply; explain and notify the prescriber
Quantity synchronisation	Several repeat dates, frequent requests	Adjust quantities to align repeats
Agreed optimisation	ICB or PCN protocol agreed with practices	Follow the approved protocol and notification

Record the reason, action and communication contemporaneously

Source: Prescription Management Guidance, Annex 2, Table 1. More detail: Webinar 4 (EPS and messaging)

Prescription management: exclusions



Outside competence

Any intervention outside your competence and scope (quantity synchronisation excepted).

Unclear intent

Unclear diagnosis or intent, or the patient needs another clinician's review.

High-risk medicines

Specialist, shared-care, monitored and controlled drugs, unless locally agreed.

Product exclusions

Items not routinely prescribed, dressings, appliances, local ICB exclusions.

National restrictions

Regulation exclusions, OTC and P medicines, brands without a clinical reason.

Financial gain

Switching for pharmacy benefit or rebates, or brand/generic for cost alone.

Source: Prescription Management Guidance, section 3 and Annex 2, Table 2

Consent and informing the original prescriber



1. Explain

Why it cannot be supplied as written, and the options available.

2. Consent

Explain benefits, risks and differences; record informed consent.

3. Capacity

If capacity is lacking, follow the Mental Capacity Act and local safeguarding.

4. Prescribe and record

Issue your own EPS prescription; record the reason, action and communication.

5. Mark not dispensed

Mark the replaced EPS item as not dispensed.

6. Inform the prescriber

Agreed route, same or next working day, stating any action needed.

Sources: Prescription Management Guidance, sections 4, 5 and 7; Prescribing Specification 4.24 and 6.5

Scenario 2: three problems on one prescription

Case study 2 of 3 · Prescription management ·

The scenario

Mr Hussain brings in a repeat prescription with three issues.

Ramipril 5 mg capsules are out of stock nationally; 5 mg tablets are available. No SSP applies.

Methotrexate 2.5 mg tablets are unavailable at the wholesaler. He asks for 10 mg tablets instead.

Atorvastatin is missing this month. He says the GP “must have forgotten”.



Which response is appropriate?

A Resolve all three. He needs his medicines and you are an NHS PCP.

B Prescribe ramipril tablets. Escalate methotrexate. Check the GP record before acting on atorvastatin.

C Prescribe ramipril and methotrexate. Atorvastatin can wait.

D Send all three back to the GP practice.

Choose A, B, C or D.

Discuss in chat: what local agreement would you need with practices to make this work?

More detail: Webinar 4 (EPS and post-event messages)

Scenario 2: debrief

Answer: B

An equivalent formulation is permitted. Methotrexate is excluded unless locally agreed and you are competent, and an omission must be confirmed, not taken on the patient's word.



Why A, C and D are incorrect

- Methotrexate is high risk; a strength change can cause serious harm, patient safety alert 10mg are not recommended
- Omissions need confirmation, not patient testimony alone
- Sending everything back ignores a safe, permitted fix



What to do

- Ramipril: prescribe 5 mg tablets with consent
- Methotrexate: contact the prescriber or specialist
- Atorvastatin: check the GP record or contact the practice first
- Inform the GP of every intervention



Evidence to hold

- Consent and rationale in the record
- Replaced EPS item marked not dispensed
- Post-event message to the GP
- Record of the methotrexate escalation

Ask "can routine dispensing fix this?" and "is this within my competence?" before prescribing.

Sources: Prescription Management Guidance 2.1, 2.3, 3.1 and Annex 2

Clinical risk: consent, GP records and safety-netting



1. Verbal consent

Obtain and record consent to the service before any prescribing consultation.

2. GP record access

With consent, check the GP or other clinical record unless there is good reason not to.

3. Missing information

If you cannot verify key information, use judgement; refer to the GP if unsafe.

4. Safety-netting

Tell patients or carers what to do if symptoms worsen or do not improve in time.

5. Urgent referral

Sepsis, severe infection or red flags: refer urgently.

6. Documentation

Objective records showing reasoning, options considered and the GP message sent.

Sources: Prescribing Specification 4.13 to 4.15; Clinical Prescribing Guidance 2.5, 2.7 and 2.20 to 2.23

What to document in a clinical consultation



1. Inspection and history

Appearance; presenting complaint, PMH, social history, allergies, medicines.

2. Observations

Temperature, heart rate, BP, respiratory rate, oxygen saturation: record values.

3. Examination

What you examined and what you found, e.g. throat, otoscopy, capillary refill.

4. Red flags

The red flags you checked for, including the negatives.

5. Diagnosis and treatment

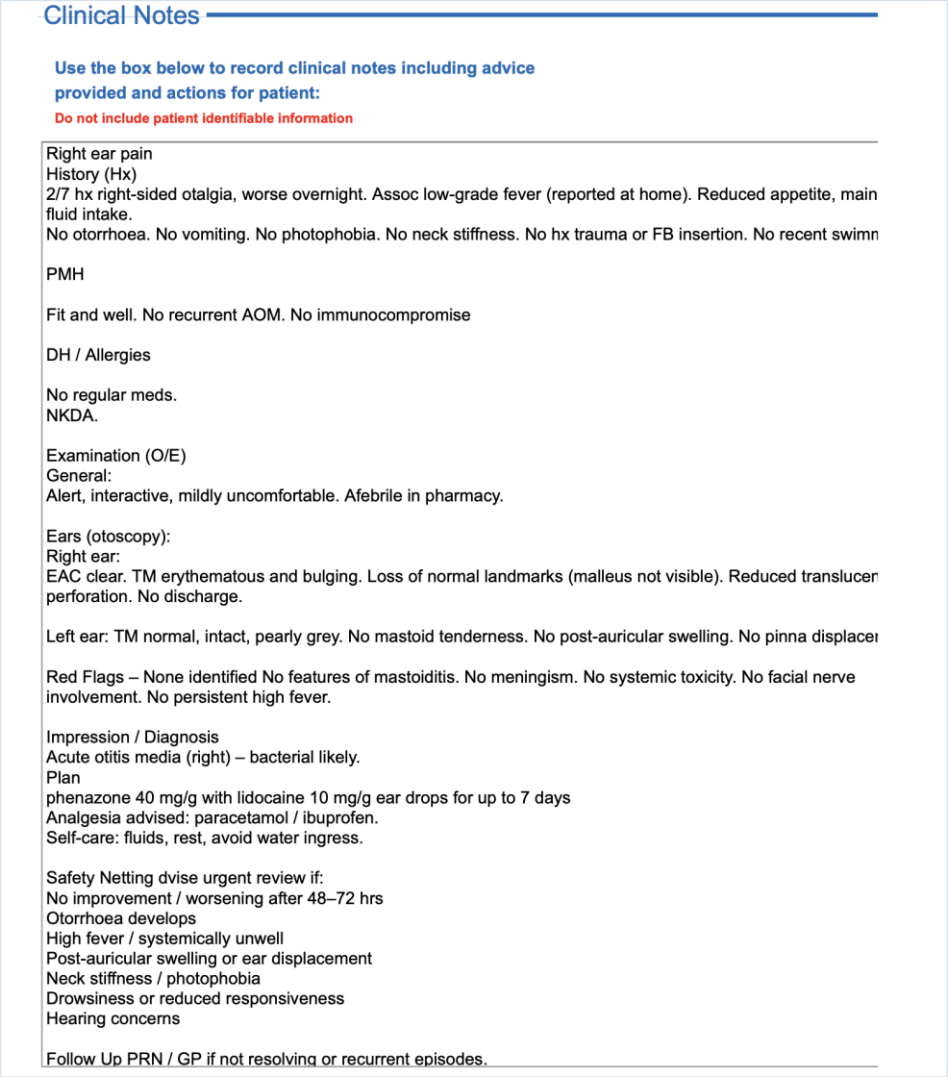
Working diagnosis, reasoning, options discussed, drug, dose and duration.

6. Safety net

What to watch for, when and where to seek help, follow-up and GP message.

If it is not written down, it did not happen: the record is your evidence of competence and safe practice.

Example: a complete consultation record



Clinical Notes

Use the box below to record clinical notes including advice provided and actions for patient:

Do not include patient identifiable information

Right ear pain
History (Hx)
2/7 hx right-sided otalgia, worse overnight. Assoc low-grade fever (reported at home). Reduced appetite, main fluid intake.
No otorrhoea. No vomiting. No photophobia. No neck stiffness. No hx trauma or FB insertion. No recent swimn

PMH

Fit and well. No recurrent AOM. No immunocompromise

DH / Allergies

No regular meds.
NKDA.

Examination (O/E)
General:
Alert, interactive, mildly uncomfortable. Afebrile in pharmacy.

Ears (otoscopy):
Right ear:
EAC clear. TM erythematous and bulging. Loss of normal landmarks (malleus not visible). Reduced translucer perforation. No discharge.

Left ear: TM normal, intact, pearly grey. No mastoid tenderness. No post-auricular swelling. No pinna displacer

Red Flags – None identified No features of mastoiditis. No meningism. No systemic toxicity. No facial nerve involvement. No persistent high fever.

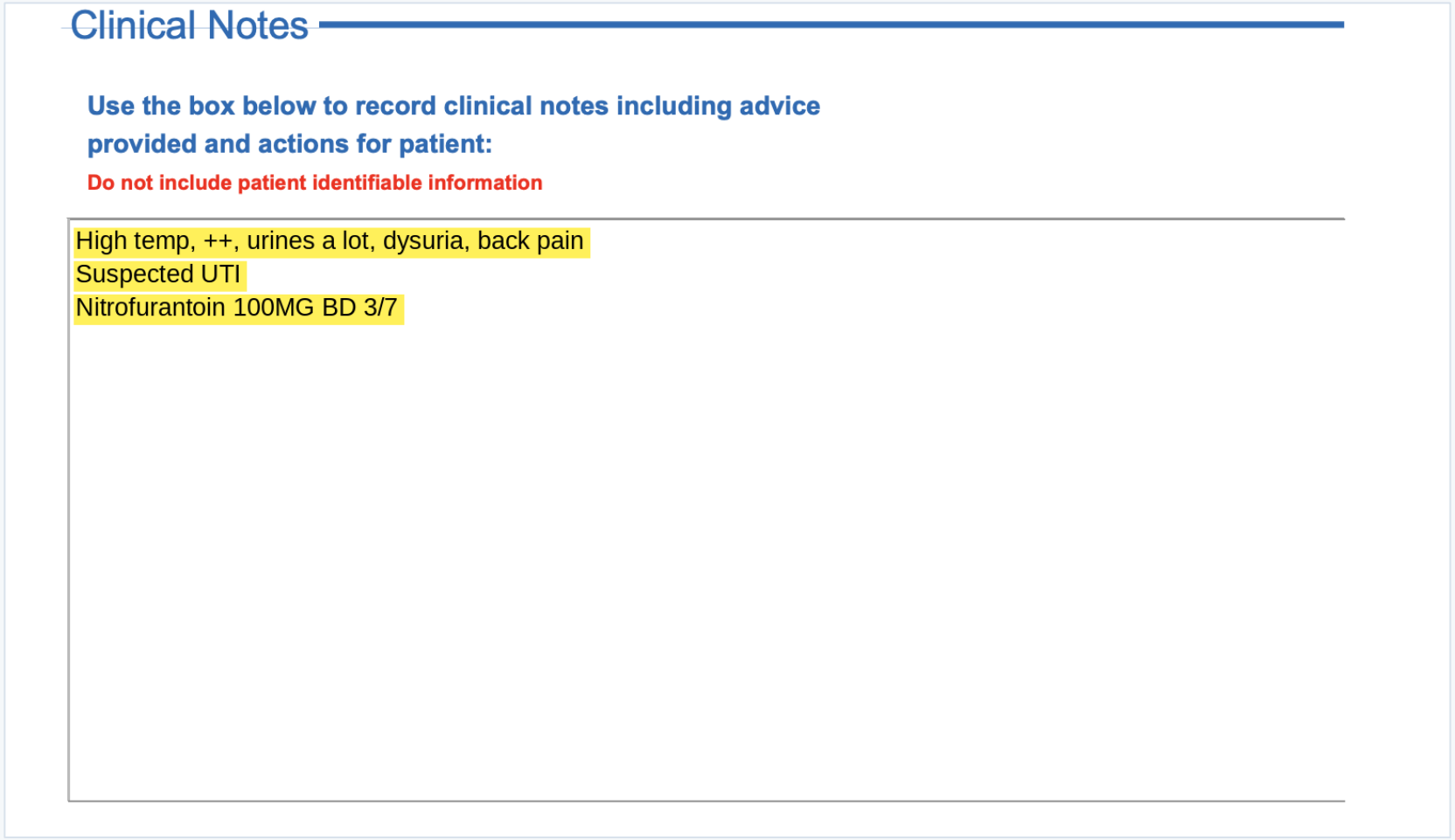
Impression / Diagnosis
Acute otitis media (right) – bacterial likely.
Plan
phenazone 40 mg/g with lidocaine 10 mg/g ear drops for up to 7 days
Analgesia advised: paracetamol / ibuprofen.
Self-care: fluids, rest, avoid water ingress.

Safety Netting dvise urgent review if:
No improvement / worsening after 48–72 hrs
Otorrhoea develops
High fever / systemically unwell
Post-auricular swelling or ear displacement
Neck stiffness / photophobia
Drowsiness or reduced responsiveness
Hearing concerns

Follow Up PRN / GP if not resolving or recurrent episodes.

Anonymised example record. Every heading is completed, including relevant negatives.

Example: unacceptable consultation record



The highlighted text is the whole record for this consultation. What is missing?

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The minimal record: what is wrong?

Key risk

High temperature with back pain points to possible pyelonephritis: ***REFER*** rather than treat as lower UTI. Nitrofurantoin is not suitable for upper UTI, and the note cannot show the risk was considered.



What is missing

- Age, sex, pregnancy status
- Temperature, heart rate and other values
- What “++” means
- Allergies, medicines, renal function
- Red flags checked, including negatives



Clinical risk

- Fever and back pain are upper UTI red flags
- Wrong pathway and wrong drug if pyelonephritis
- No formulation stated (MR)
- No safety-netting or follow-up
- Hard to defend at audit or on challenge



A robust note records

- Consent and who was seen
- History, observations and examination
- Red flags and the decision to refer or treat
- Reasoning, drug, dose, formulation and duration
- Safety-netting and the GP message

Document as if someone will question your decision: one day they may.

Sources: Clinical Prescribing Guidance, UTI pathway and section 2; Prescribing Specification, section 6

Example: what the record should say

Clinical Notes

Use the box below to record clinical notes including advice provided and actions for patient:

Do not include patient identifiable information

Presenting complaint
Dysuria and frequency, right-sided back (loin) pain, fever.
History (Hx)
3/7 dysuria, frequency and urgency. 1/7 right loin pain, fever and rigors overnight. Nausea, vomited x1 today; struggling to keep fluids down. No visible haematuria. No vaginal discharge. No new confusion.
34-year-old female. Not pregnant (LMP 2/52; pregnancy test negative). Not breastfeeding.
PMH / DH / Allergies
No diabetes, renal disease, immunosuppression or catheter. 1 UTI in last 12 months. Combined oral contraceptive only.
Allergy: penicillin (rash).
Consent and records
Verbal consent to consultation and GP record access. GP record reviewed: no renal history, no recent antibiotics.
Observations
Temp 38.9°C. HR 112 bpm. BP 104/68 mmHg. RR 22/min. SpO2 97% on air. Alert. NEWS2 6.
Examination (O/E)
Appears unwell, flushed. Right renal angle tenderness. Mild suprapubic tenderness. No rash. No mottling.
Red flags
Fever with loin pain and rigors. Vomiting: unable to tolerate oral treatment. Tachycardia and raised RR: possible sepsis.
Impression
Suspected acute pyelonephritis with possible sepsis. Upper UTI and systemically unwell: outside the Pharmacy First UTI pathway. Not suitable for treatment in the pharmacy.
Plan / action
URGENT REFERRAL TO A&E NOW. Reason and urgency explained; patient agrees. Partner driving her immediately (not driving herself). Call 999 if confused, drowsy, breathless, faint or mottled before arrival. No antibiotic supplied.
Written summary given to take to A&E.
Communication
Post-event message to GP sent same day documenting findings and A&E referral.
Pharmacist: [name], GPhC [number]. Date/time recorded.

Key questions to ask

- Urinary symptoms: onset, dysuria, frequency, haematuria?
- Loin or back pain? Fever, rigors, nausea or vomiting?
- Age, sex, pregnancy or breastfeeding?
- Diabetes, kidney disease, catheter, immunosuppression?
- Recurrent UTI, recent antibiotics, allergies?

Red flags: refer urgently

- Fever with loin pain or rigors
- Vomiting or unable to take oral medicines
- Raised heart or breathing rate, low BP, new confusion: possible sepsis
- Pregnancy with upper UTI symptoms
- Reduced urine output

Mock-up for the same presentation: full assessment, red flags and a documented urgent A&E referral.

Clinical risk: safeguarding and minors

Under 16s

For contraception, document a Fraser assessment for anyone under 16; if not competent, refer. Use local safeguarding contacts and advice.

Capacity

Where someone aged 16 or over may lack capacity, assess capacity to consent and follow the Mental Capacity Act.



Pregnancy in under 16s

In some Pharmacy First pathways prescribing may be appropriate, subject to safeguarding considerations and reporting where needed.

Service risk assessment

Must include safeguards for high-risk patients, complex presentations, vulnerable individuals and minors. Escalate concerns promptly.

Sources: Prescribing Specification 7.2; Clinical Prescribing Guidance, Appendices A and C; PCS specification

Clinical risk: antimicrobial stewardship and best value



Antimicrobial stewardship

Antibiotics only when indicated, using local formularies, NICE, UKHSA guidance and TARGET.

Best value prescribing

The most appropriate, cost-effective product, generic where possible; not routine OTC items. Refer to GMMMG.

Off-label and unlicensed

Off-label only where supported. Unlicensed medicines are not prescribed: refer.

Sources: Clinical Prescribing Guidance 2.11 to 2.19; Prescribing Specification 4.20 and 10.1

Clinical risk: never for yourself, and care with people you know

Yourself

NHS PCPs must not provide any part of the service to themselves, under any circumstances.

People you know

Family, friends, colleagues: follow GPhC section 4.1, exceptional cases only, recorded.

Why it matters

Objectivity and a full clinical picture are harder to assure.

Practical controls

Refer to another NHS PCP or the GP; cover it in the SOP and audit.



Sources: Prescribing Specification 4.21; GPhC In practice: Guidance for pharmacist prescribers, section 4.1

Remote and video consultations: what must be face-to-face

All consultations must be verbal and provided at or from the pharmacy premises linked to the Prescribing Cost Centre.

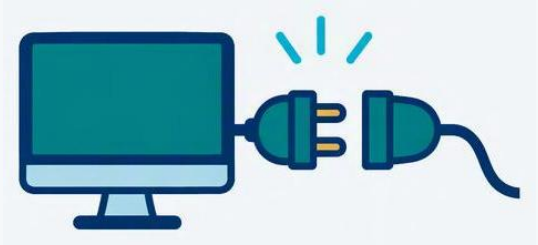
Service / pathway	Remote option	Face-to-face only?
Pharmacy First: UTI, sinusitis, sore throat, impetigo, insect bites, shingles	Live video only	**No**
Prescriber-only: migraine, allergic rhinitis in children	**As the PF specification allows**	**No**
Otitis media, otitis externa, acne, skin infections, scabies	Not permitted	**Yes, on premises**
Pharmacy Contraception Service	Telephone or video	**No**

Distance selling pharmacies cannot see patients face-to-face, so cannot provide the face-to-face-only pathways.

If remote assessment is not clinically adequate, switch to face-to-face or refer

Sources: Prescribing Specification 3.9 to 3.12; Pharmacy First and Pharmacy Contraception service specifications

Standards for remote assessment



Clinically appropriate

Decide case by case whether remote assessment is safe; switch to face-to-face where needed.

Video quality

The contractor ensures video quality allows an appropriate clinical assessment.

Confidential setting

Arrangements at the pharmacy that keep telephone or video conversations confidential.

Identity and consent

Confirm who you are speaking to and record consent, as for any consultation.

Measurements

Use validated equipment; accept patient-supplied BP or BMI only where clinically appropriate.

Records

Record the consultation mode, findings and reasoning contemporaneously.

Sources: Prescribing Specification 3.12; NHS England remote and video consultation guidance

Scenario 3: “Can we just do it on video?”

Case study 3 of 3 · Remote consultations, minors and scabies ·

The scenario

A parent calls asking for a video consultation for their 14-year-old’s itchy rash, which sounds like scabies.

All four people in the household are itching. They want “one prescription for everyone” today.

The NHS PCP on duty has scabies in her declared scope.

The family lives 15 minutes from the pharmacy.



What is the right approach?

A A video consultation for the 14-year-old, then one prescription covering the household.

B Face-to-face consultations at the pharmacy, each person in their own consultation, with exclusion and safeguarding checks.

C A telephone consultation and advise buying permethrin over the counter.

D Refer everyone to the GP because a child is involved.

Choose A, B, C or D.

Discuss in chat: how does your SOP route requests for face-to-face-only pathways?

More detail: Webinar 5 (SOPs and service delivery)

Scenario 3: debrief

Answer: B Scabies is a face-to-face pathway. Treat household contacts at the same time, each in their own consultation, applying the exclusions and safeguarding checks in the guidance.



Why A, C and D are incorrect

- Scabies must be seen face-to-face, so neither video nor telephone applies
- One prescription cannot cover four people
- Age 14 is within the pathway; being a minor is not a reason to refer



What to do

- Book face-to-face appointments
- Check exclusions: under 1, crusted scabies, care-home links
- Consider safeguarding and contact management
- Explain two applications 7 days apart; safety-net



Evidence to hold

- A separate record for each person
- Consent recorded, including for the 14-year-old
- Post-event message to each GP
- Rationale for any referral

Check the consultation mode before you book: some pathways can only be seen in person.

Sources: Prescribing Specification 3.11; Clinical Prescribing Guidance, Appendix B4

Case study: a doctor questions a prescriber's competence



The concern

A doctor asked why a pharmacist was prescribing for this condition.

Ongoing training

Numerous training records: learning is current, not a one-off.

100 audits

Audited consultations showing safe, consistent prescribing over time.

8 testimonials

Independent accounts from doctors and other healthcare professionals.

Portfolio of evidence

Evidence mapped to the declared scope of practice.

Peer review

Peers tested clinical judgement, not just the records.

Key point: competence was evidenced, not asserted, and ongoing training kept it current.

Quick-fire true or false?

1

An NHS PCP can switch to a PGD for a Pharmacy First consultation they feel less confident with.

2

Acne, otitis externa and scabies consultations can be carried out by video.

3

Prescription management can be used to switch a brand to a generic to save cost.

4

A newly qualified pharmacist can be asked to use PGDs first while building competence.

5

A Pharmacy Contraception consultation can go ahead if the patient declines GP notification.

6

An NHS PCP may provide the service to themselves if no other prescriber is available.

Quick-fire: the answers

Four myths and two truths. Each one is covered in detail today.

FALSE **Statement 1**

All NHS PCPs at the pharmacy must use prescribing for these consultations. If it is outside their scope, refer to another competent NHS PCP.

FALSE **Statement 2**

Acute otitis externa, acute otitis media, acne, mild skin infections and scabies must be face-to-face on the premises.

FALSE **Statement 3**

Switching for the pharmacy's financial benefit, or brand to generic for cost alone, is not permitted.

TRUE **Statement 4**

Contractors may ask newly qualified pharmacists to use PGDs initially, then onboard them as NHS PCPs once competent.

TRUE **Statement 5**

Consent to notify the GP is sought. If declined, or the patient has no GP, the consultation can still proceed.

FALSE **Statement 6**

NHS PCPs must not provide any part of the service to themselves, under any circumstances.

Sources: Prescribing Specification 3.11, 4.3, 4.14, 4.21 and 5.4; Prescription Management Guidance 3.4

Competent and in scope: key takeaways and next steps

What to check in your own pharmacy over the next 30 days



Six things to remember

- **Scope is specific.** Name pathways, patient groups, limits and evidence; update annually or on change.
- **Grow scope with a plan.** Development plan, supervision and a clinical risk assessment first.
- **Onboarded means prescribing.** NHS PCPs cannot fall back on PGDs; NQPs may use PGDs before onboarding.
- **Know the guidance.** MAY / MAY NOT tables, exclusions and face-to-face rules for each pathway.
- **Prescription management is narrow.** No CDs or high-risk medicines without local agreement; always inform the prescriber.
- **Risk in every consultation.** Consent, GP record, safety-netting, safeguarding, AMS, best value, never for yourself.



Your action plan



Collect a scope declaration from every NHS PCP



Check each one against the RCPharm framework



Start development plans for pathway gaps



Map face-to-face and remote rules in the SOP



Agree prescription management routes with practices



Update the risk assessment for minors and vulnerable people

Questions? Post them in chat now or note your biggest scope gap to take back to your team.

Further detail: Webinar 4 (digital systems), Webinar 5 (go-live, audit and incidents)

Keep calm, CPGM are here for you

Thank you for joining. Questions about prescriber competence, scope or getting started? Community Pharmacy Greater Manchester can help.

CPGM

ALLIED HEALTH TRAINING

