

INDEPENDENT PRESCRIBING BY PARAMEDICS IN THE UK: THE REALITY AND IMPACT ON PATIENT CARE.

International Roundtable on Community Paramedicine. June 2024

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CONNECTION BETWEEN INDEPENDENT PRESCRIBING AND PRIMARY CARE: PATIENT OUTCOMES AND IMPACT ON PARAMEDICS

- The session will briefly review the journey to achieve independent prescribing for UK paramedics, including the political and practical aspects of changing legislation.
- Developing the case of need will be reviewed to highlight the issues that the proposal sought to resolve for patients, such as the need to apply patient-centred care using protocol-based approaches.
- The discussion will then focus on the findings from the qualitative studies undertaken in the wake of the introduction of independent prescribing among UK paramedics, and how this reality impacts on patient care and paramedic practice.

INTRODUCTION

Independent prescribing by paramedics was passed into UK law on the 1st April 2018.

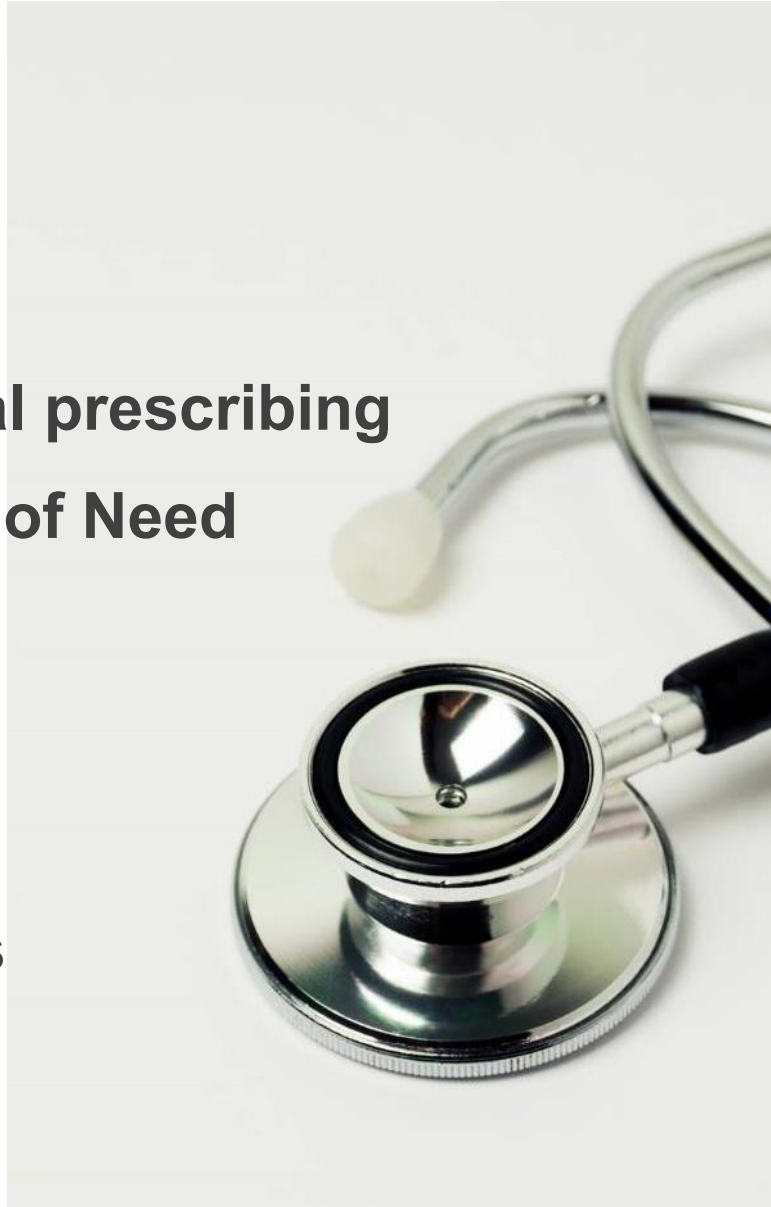
Paramedic prescribing was first suggested in 2009.

Today, there are 2116 of the 36,844 paramedics in the UK with annotated registration as independent prescribers.



THE JOURNEY

- Origins of non-medical prescribing
- Policy drivers & Case of Need
- Barriers
- Legislation change
- Impact on patients
- Impact on paramedics





ORIGINS OF NON-MEDICAL PRESCRIBING IN THE UK

ORIGINS OF NON-MEDICAL PRESCRIBING

Early Years (1980s-1990s)

- Background
 - Initial reliance on doctors for prescriptions.
 - Growing need for expanded access to medications.
- Key Developments
 - Cumberledge Report (1986)
 - Crown Reports (1989 and 1999)
 - Medicinal Products: Prescription by Nurses etc. Act (1992)
- Impact
 - Improved patient access to medications.
 - Enhanced role and autonomy for non-medical healthcare professionals.



Medicinal Products: Prescription by Nurses etc. Act 1992
1992 CHAPTER 28

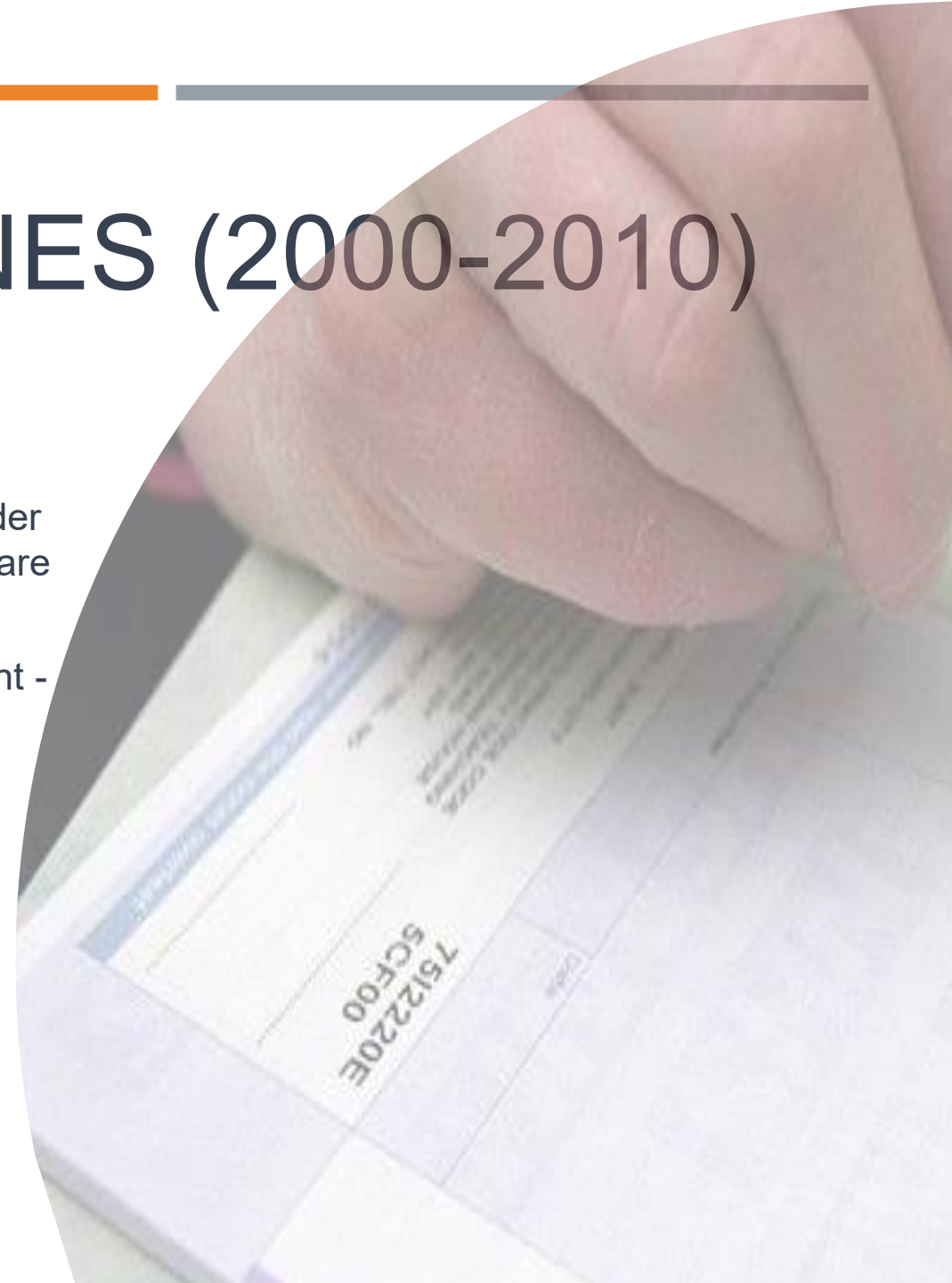
An Act to make provision with respect to medicinal products prescribed or otherwise ordered by registered nurses, midwives and health visitors.

[16th March 1992]

LEGISLATIVE MILESTONES (2000-2010)

Shaping Non-Medical Prescribing Through Legislation

- Legal Framework
 - The Prescription Only Medicines (Human Use) Amendment Order 2003 – Nurse extended formulary prescribing starts (linked to care plan).
 - 1999-2002 development of changes leading to 2006 amendment - Pharmacists (SP) and further expansion of nurse prescribing
- Collaborative Approaches
 - Collaboration between professional bodies, government, and healthcare institutions to discuss broadening of HCP groups
 - 2010 ministerial consultation on paramedic prescribing
- Achievements
 - Widening the scope of non-medical prescribing.
 - Strengthening the role of pharmacists in prescribing.





POLICY DRIVERS & CASE OF NEED

CONSOLIDATION & EXPANSION (2010-2020)

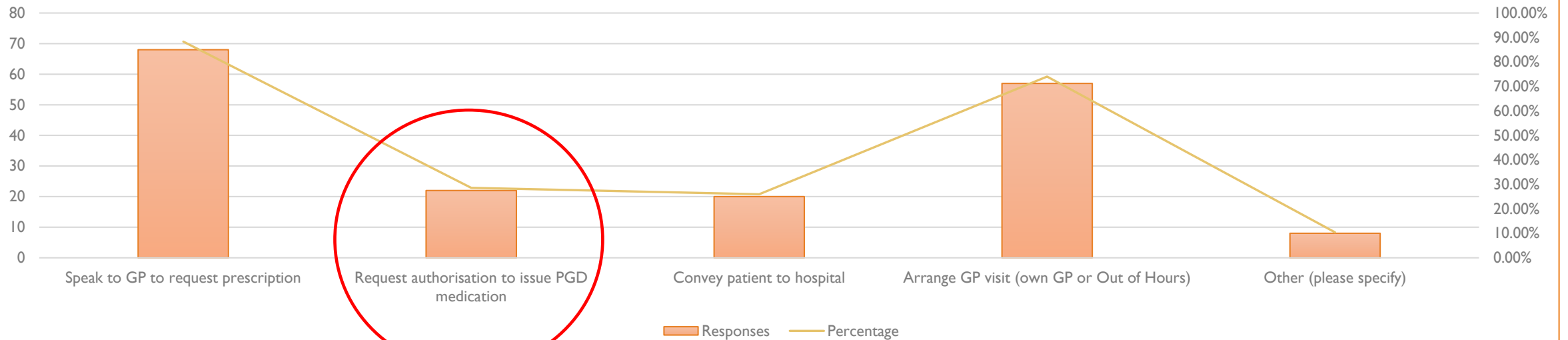


Advancements in Non-Medical Prescribing

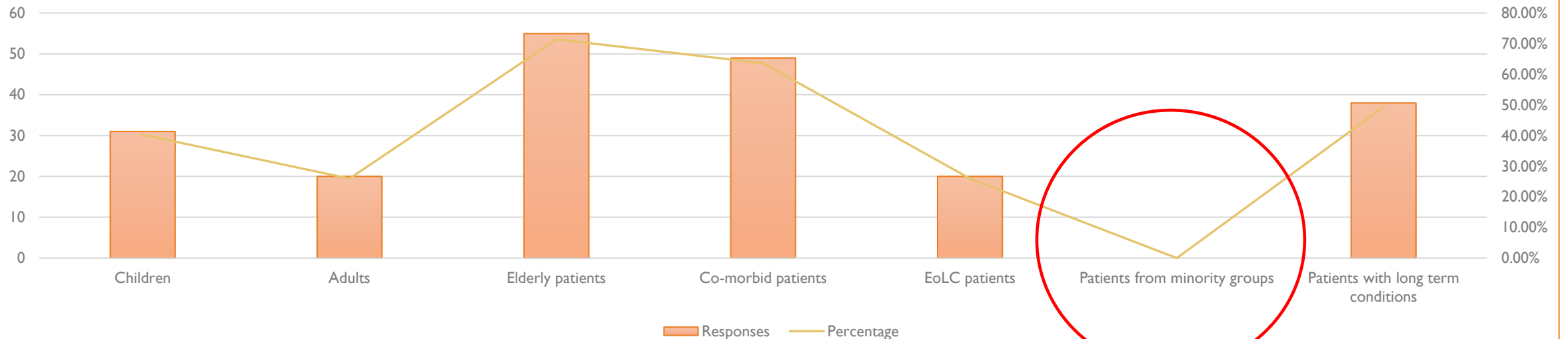
- Professionalisation
- Development of educational programs and standards.
- Integration of non-medical prescribing into professional curricula.
- Role Diversification
 - Expansion of prescribing authority to a wider range of healthcare professionals.
 - Recognition of non-medical prescribers in multidisciplinary teams.
- Patient-Centric Approach
 - Emphasis on patient-centred care and shared decision-making.
 - Enhanced patient satisfaction and healthcare outcomes.



When you find yourself unable to issue a PGD, what other methods do you use to obtain the correct care for your patient.



Which patients are most likely to be outside PGD inclusion in your experience?





BARRIERS

■ IT issues

“We did encounter some difficulty getting set up with the computer system once I was registered as a prescriber. It took a couple of weeks to fathom out a ‘work around’ for getting set up with that and now we are having issues. We have just logged electronic prescribing. We are having similar issues again just because it doesn’t recognise HCPC numbers.” (Paramedic working in Primary Care)

■ Controlled drugs

“A lot of the prescribing that we need is obviously opiate based pain relief, and we also do procedural sedation here. So, we can’t do procedural sedation without it being prescribed for us, or we can’t prescribe morphine or morphine derivatives, all those sorts of medications that patients need”. (Consultant ACP in ED).

■ Managing expectations (of patients and colleagues)

“The risk is that people think, ‘Oh, he can just write my prescription now’, but in my mind, I still am very new as a prescriber, and what I would not like or what I’m conscious of is stepping outside of my fledgling prescribing skills (...). So, I guess I keep telling everyone, ‘Don’t start coming to me and ask me to write repeat prescriptions’.” (Clinical Lead WIC)

Table 2. Author-inferred commonalities—paramedic profession and other AHP groups

- Overwhelming willingness of APs to become PIPs
- Established ability to safely deliver medications in a diverse range of settings
- High predicted benefits for patients through improved access to consultations and medications
- Extension of NMP rights to other AHPs, including paramedics, is featured in the NHS modernisation agenda
- Political drivers to support the expansion of NMP rights to paramedics
- Increasing public support and acceptance of NMP
- Resistance from medical colleagues to expand prescribing rights to AHP groups due to a perceived lack of confidence—mainly attributable to the lack of training standardisation comparable to that of a medical degree
- Work semi-autonomously/autonomously—concerns over the ‘loose cannon’ in unsupervised practice situations.

The background of the slide features a photograph of a Gothic-style building with ornate windows and a central tower. In the foreground, there are several flags, including the flag of the United Kingdom (Union Jack) and the flag of the Netherlands (horizontal stripes of red, white, and blue).

PAPERS/ OTHER ITEMS

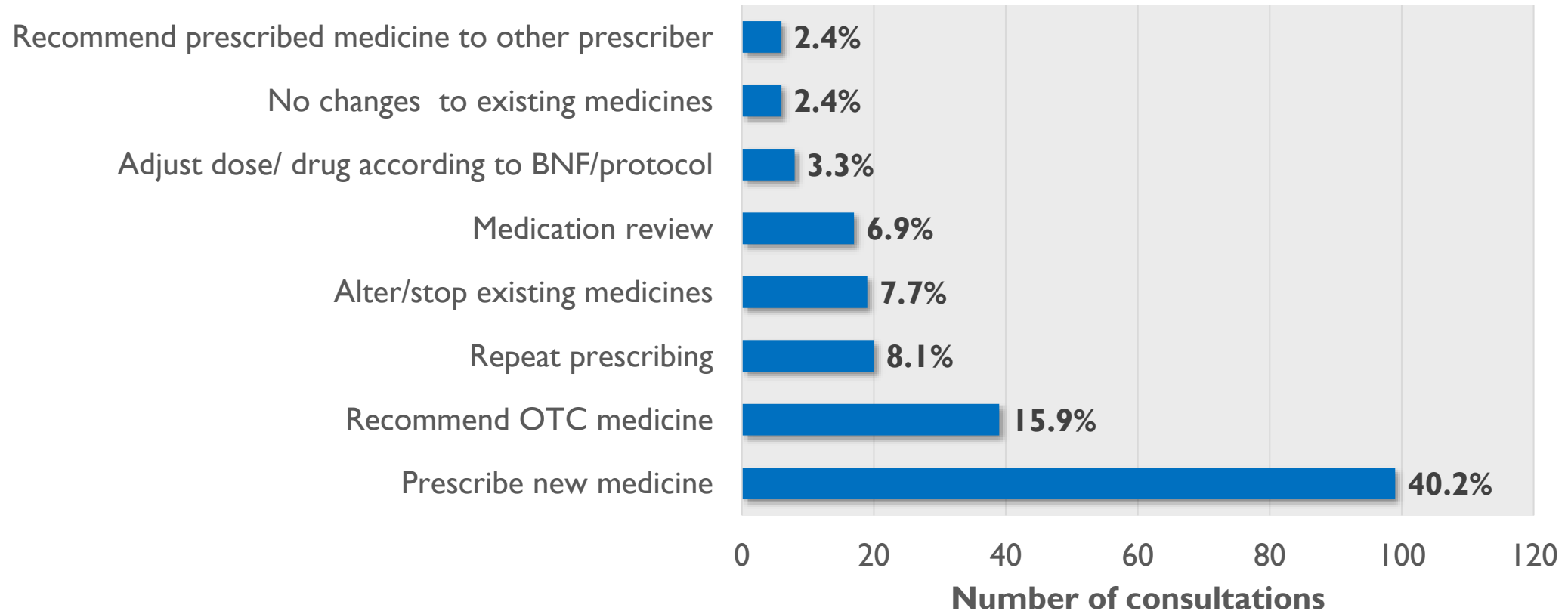
The Commission considered and discussed feedback from the ad hoc group on proposals for Independent Prescribing for Paramedics and Diagnostic Radiographers. In conclusion, the Commission endorsed the ad-hoc group's recommendations to support independent prescribing for paramedics. They also endorsed the recommendation that independent prescribing for diagnostic radiographers should not be supported at this time.

LEGISLATION CHANGE



IMPACT ON PATIENTS

PRESCRIBING/MEDICINES MANAGEMENT ACTIVITIES



- **Medicines management decision made in 62.6% consultations (1 every 1.59)**
- **Independent prescribing used in 40.2% consultations (1 every 2.48)**

Outline of proposal

It is proposed that amendments to medicines legislation are made to allow paramedics (working at an advanced level) to prescribe medicines independently. 5 Options for introducing independent prescribing by paramedics were proposed and a breakdown of these options can be found in Table1 overleaf. It is also proposed that consideration be given to paramedic independent prescribers being allowed to mix licensed medicines prior to administration and be able to prescribe independently from a restricted list of controlled drugs.

**PGD = Patient Group
Direction**

Clinical Practice Guidance
and Medical Directive

PGDs do facilitate a means of administering specific medicines, they are simply not dynamic, nor responsive enough to be effective in many clinical settings given the diversity of medical conditions encountered. Studies by Smalley (2006), Stenner et al (2009; 2011) and Tinelli et al (2013) all found widespread acceptance of NMP, which not only demonstrated consistently high levels of patient satisfaction, but also safe and effective medicines provision.

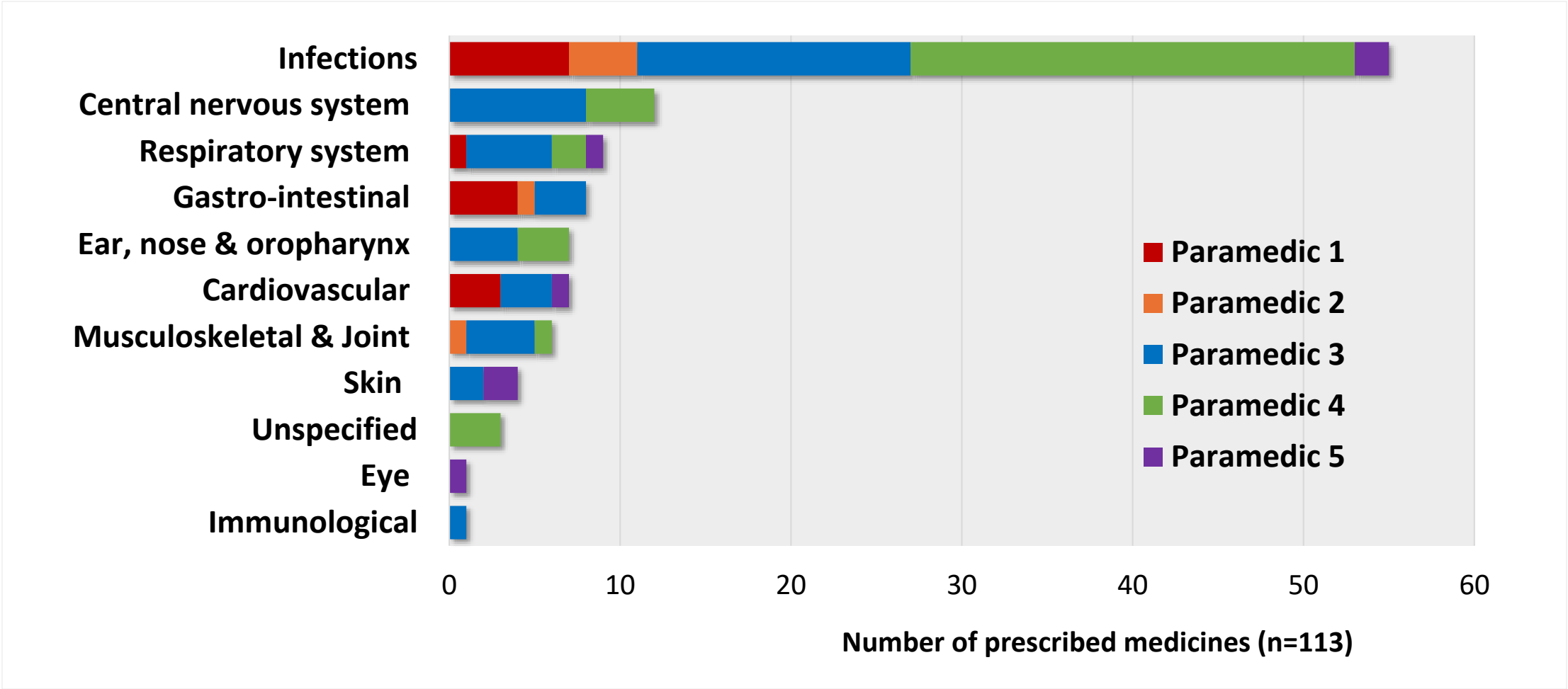
(Griffin, 2015)

EVIDENCE BASE, SAFETY, & BENEFITS TO PATIENTS.

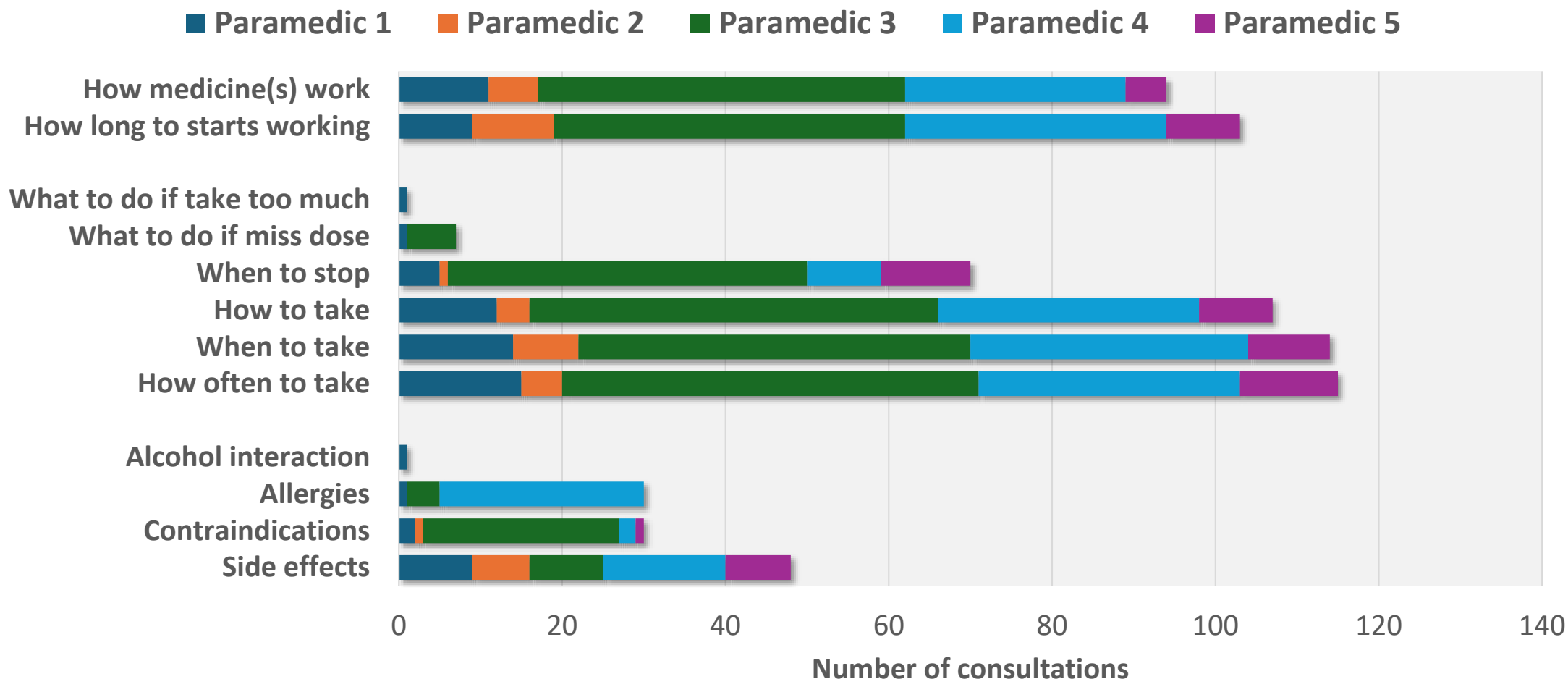
- Stated benefits versus realised benefits
- Additional benefits
 - Diversification of roles early on beyond its initial scope (i.e. nurses seeing patients not registered with a GP)
 - Prescribing applications in other professions (i.e. in physio & podiatry)
- Unrealised risks (workload ↑, safety ↓)
- Safe & effective care. “...*nurse prescribing is as safe as medical prescribing.*” (Funnell et-al, 2014)



MEDICINES PRESCRIBED (N=113)



INFORMATION GIVEN ABOUT MEDICINES



- Information given in 56.1% consultations (1 every 1.78)

INFLUENCE OF HIGHER EDUCATION

- Differences between how paramedics with MSc (n=3) versus BSc/FdSc (n=2) used IP qualification explored
- MSc paramedics demonstrated higher level of engagement in medicines management:
 - Undertook medicines management decisions more frequently (75.4% Vs 48.3%, $p<0.001$)
 - Prescribed more often (46.9% Vs 32.8%, $p=0.024$)
 - Provided wider range of information on medicines ($p=0.005$)
- Prescribed antibiotics/antifungals less frequently (29.6% Vs 46.4%, $p=0.036$)

#NOTALLPARAMEDICSWEARGREEN



Antonia Cook
Expedition Paramedic



John Eyre
Motorsport Paramedic



Norbert Majer
Seafarer Paramedic,
working on cruise ships



Greg Garrett
Community Matron,
North Somerset
Community Partnership



Ross Bate
Urgent Care Team
Manager/ACP, Preston
Grove Medical Centre



James Ackroyd-Smith
Resuscitation
Practitioner, Richmond
Pharmacology



Chris Ashton
Stroke Network
Coordinator,
Manchester



Fraser Rowbotham
Air Sea Rescue
Winchman, Advanced
Paramedic, Brunei



Joseph Francis
MSc Co-Lead for
Advanced Clinical
Practice, University
of Exeter



David Monk
Operations Manager,
Cambridge University
Hospitals



Ash Capel
Head of Quality &
Patient Safety, Adult
Community Services,
Virgin Care



Graham Turner
Ward Manager, Martlets
Hospice



Jamie Jones
Health, Safety and High
Risk Advisor for media,
TV and film



Sean Hegarty
Single Point of Access
Case Manager, Sirona
Care and Health



Craig Prentice
Advanced Clinical
Practitioner, Emergency
Medicine



Tracy Nicholls
Chief Executive, College
of Paramedics



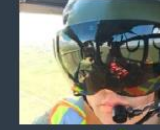
Paddy Ennis
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Ciaran McKenna
Northern Ireland
Specialist Transport
and Retrieval Service
Manager



Rhian Monteith
Clinical Advisor to
NHSB and Health
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Paul Benton
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Joanna Garrett
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Kirsty Lowery-Richardson
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West Yorkshire and
Harrogate ICS



Nigel Hare
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Registered Manager,
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Richard Smith
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Ghulam Farooque
Advanced Clinical
Practitioner in Primary
Care, Rotherham
District General
Hospital



Adele Swallow
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Partnerships Manager,
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Commissioning Group



Ioney Chatttoo
Clinical Team Leader
and Police Custody
Paramedic,
Leeds Community
Health NHS Trust



Dan Bevis
National Head of
Ambulance Operations,
St John Ambulance

IMPACT ON PARAMEDICS

- **Griffin (2015)**

- ...how prescribing rights for advanced paramedics (APs) has the potential to facilitate safe and efficient access to medicines, affording a robust rationale to support its introduction, and illustrates some of the potential benefits for service-users, the paramedic profession, healthcare providers/employers, and service commissioners.

- **Bedson & Latter (2018)**

- The majority of participants (66/78, 84.6%) felt confident to undertake paramedic independent and supplementary prescribing and that it would enhance both their scope of practice (70/72, 97.2%) and patient care (67/72, 93.0%).

- **Clarke (2019)**

- Being able to prescribe it [medicines] and ask the nurses to give it immediately would be a huge benefit and obviously the more acute the patient presentation the more important it is we give these medicines and things in a timely manner.

- **Best (2020)**

- The definition of advanced clinical practice is important for paramedic prescribing. Guidance suggests that only paramedics in advanced clinical roles should be eligible to gain the independent prescribing qualification

- **Stenner, van Evan, Collen (2021)**

- Key benefits of prescribing included improving service capacity, efficiency and safety, and facilitating advanced clinical roles. Paramedic prescribing is most successful in settings with a high volume of same-day presentations and urgent and emergencies.



CHALLENGES IN CONSULTATION RESPONSES

“Insufficient background medical knowledge to allow formulation of differential diagnosis list

Lack of clinical examination skills and interpretation of clinical signs




Lack of clinical history taking skills and recognition of important features in clinical history

Will not know patients past medical history

Lack of pharmacological knowledge to assess risks of adverse reactions with other medication

*It is absolutely NOT possible to train up these people to do all this in a short course of 18 months or whatever. Its dangerous and **PEOPLE WILL DIE.**”*

Jeff @ Jan 9th 2007 12:59PM

Low Ranked   

Apparently none of you guys realize how bad of an idea a touch-screen is on a phone. I foresee some pretty obvious and pretty major problems here.

Outline Curriculum Framework for Education Programmes to Prepare:

- Physiotherapists
- Podiatrists
- Therapeutic Radiographers
- Paramedics

as Independent/Supplementary Prescribers

and to Prepare:

- Diagnostic Radiographers
- Dietitians

as Supplementary Prescribers

Review October 2019. May be subject to earlier review if required

Improving Patients' Access to Medicines:

A Guide to Implementing Paramedic Prescribing within the NHS in the UK

Annex F: Checklist for Potential Prescribers and/or Organisations Introducing Prescribers

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

You MUST be able to answer YES to all topics before considering non-medical prescribing.

Topic	Evidence	Self-Assessment		Standards and Guidance Documents	Your Evidence
		Yes	Needs Development		
Your Clinical Role	Your employer provides clinical services which require independent prescribing (ie you have a clear prescribing role) Your role is currently limited by not being able to independently prescribe, or is a requirement of the role you are training for				
Your Professional Qualification and Post-registration experience	You are registered with the HCPC and have no sanctions or conditions applied You have (or are working towards) an advanced practice qualification (typically MSc/other study at Masters level which fulfils the HEE definition of Advanced Practice) and have achieved the award within the last 6 years, or have evidence of continuous practice at that level if achieved to longer than 6 years ago You are, and have been, practising in your area of expertise for at least 12 months You have been qualified and registered for at least 5 years You have evidence of post-registration study (for example, DipHE or PGDip)			HEE - definition of Advanced Practice	

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Information paper

Proposed Practice Guidance for Paramedic Supplementary and Independent Prescribers.

(Draft Edition)

Please note: This document provides guidance and advice based only on the proposed changes to legislation that would permit Supplementary and Independent Prescribing by Paramedics. 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.

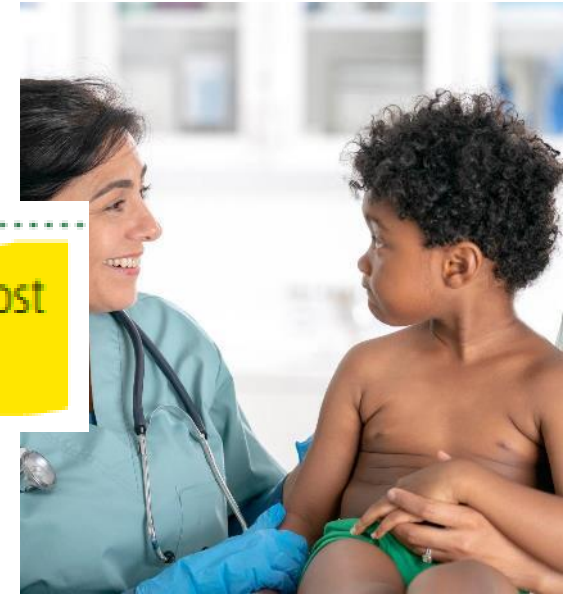
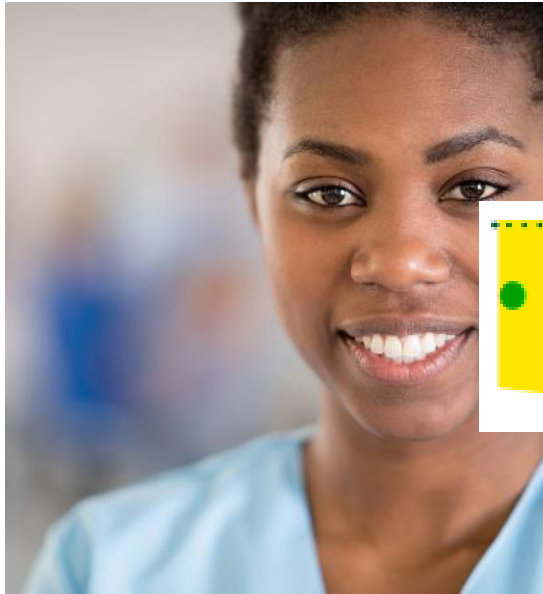
reference COP-IP002

issuing function Chief Executives Office / Medicines & Prescribing Project Lead

date of issue November 2017

version V1.18

1



- During the COVID-19 pandemic, being able to prescribe became almost essential in order to maximise remote working capabilities

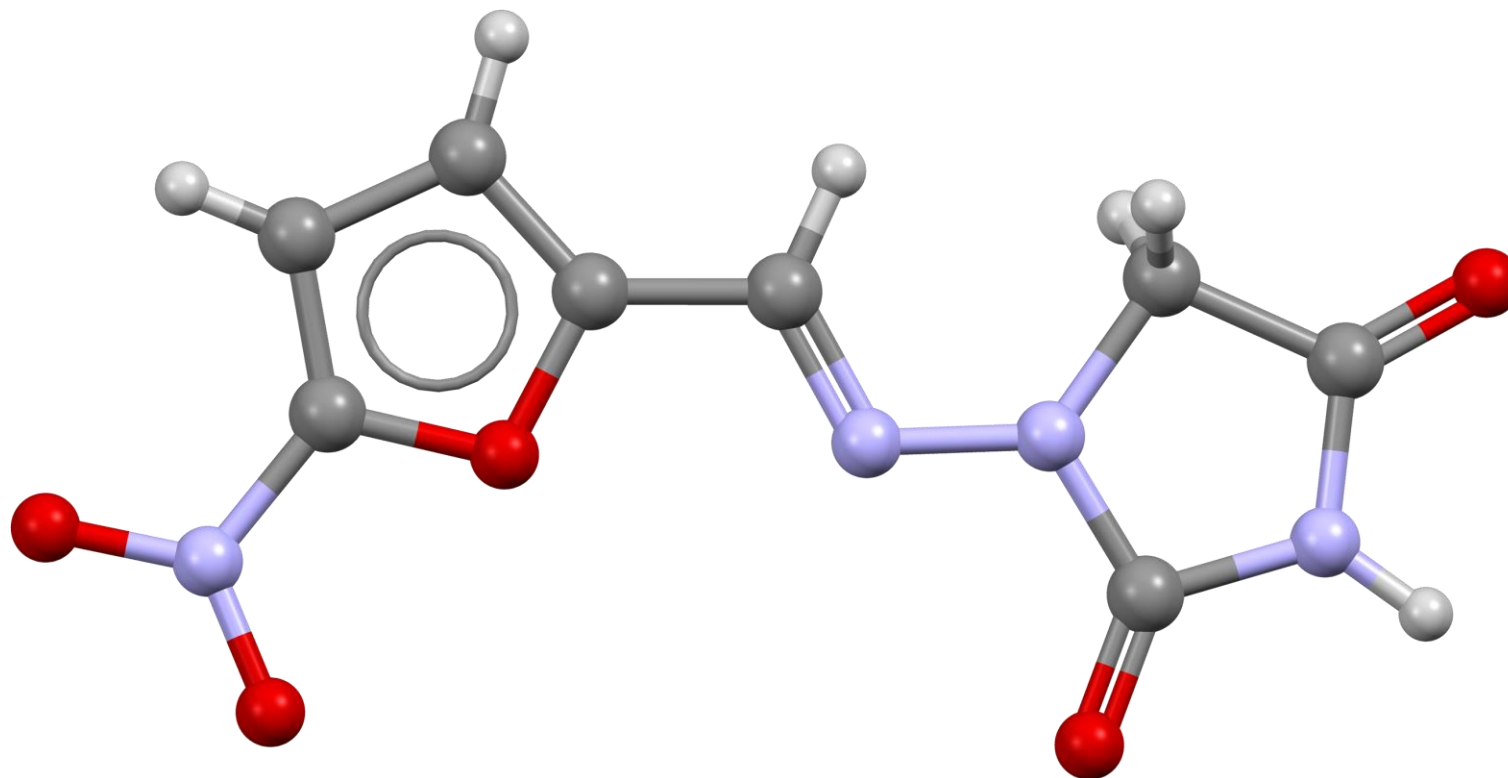


SUMMARY

Independent prescribing by Advanced Paramedics should be viewed as a gap, rather than a bolt-on or luxury, as it allows safe, patient centred care, minimises unnecessary handoffs, and prevents the inequalities that the reliance on protocols creates for patients.

THANK YOU FOR LISTENING

Any burning questions?



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Additional Entitlements ☐ SP 

☐ IP 