Chapter 1
Background to Independent Prescribing for Paramedics

Andy Collen

In This Chapter

- Introduction
- Background to non-medical prescribing
- Overview of the prescribing mechanisms
- The history of independent prescribing by paramedics
- Prescribing roles
- Rationale and case of need
- Aims of paramedic prescribing
- Conclusion
- Key points of this chapter
- References

Introduction

This chapter provides an overview of non-medical prescribing in the United Kingdom (UK). It provides a historical perspective describing how prescribing has developed for non-medical healthcare practitioners in the UK and charts the journey that paramedic prescribing has taken. It includes a contemporary take on the need for paramedic prescribing in today's healthcare context and an analysis of what this can offer patients and healthcare practice.

Background to Non-medical Prescribing

Prior to changes made in the early 1990s, prescribing medicines was restricted to doctors, dentists and veterinarians. The legal basis for prescribing medicines in healthcare is described in the Medicines Act 1968 (Legislation.gov.uk, 2015), which states the legislative and practical limitations imposed on access to medicines in order to prevent harm to patients and the wider population. It provides a framework for the licensing of medicines, and clarifies the classes and schedules of medicinal products available in the UK. As with all legislation, it can be extremely challenging

to navigate and provides very limited detail which can be easily interpreted by the layperson, but must be upheld to ensure legitimate and legal practice.

The basis of the law requires that the correct medicine is given to the correct patient in the right way (dose, presentation, formulation) and at the right time. As the Medicines Act regulates the administration, supply and licensing of medicines, it is important that medicines in practice be entrusted only to appropriate practitioners. It is these restrictions which in turn created an increasing number of practical issues for patients to access medicines in a timely way in a modernising healthcare system.

Non-medical prescribing was first proposed in the recommendations published in the Cumberledge Report (Department of Health and Social Security (DHSS), 1986), which suggested prescribing be undertaken by community nurses. The Crown Report written by Dr June Crown in 1989 (Crown, 1999) endorsed the recommendations made in the Cumberledge Report, and this led to the creation of specific legislation to allow nurse prescribing (Medicinal Products: Prescription by Nurses etc. Act 1992). Nurse prescribing developed over the subsequent years and paved the way for non-medical prescribing to be extended beyond nursing and pharmacists. The introduction of prescribing by allied health professions (AHPs) happened in 2013 when the physiotherapy and podiatry professions achieved independent prescribing responsibilities, following lobbying for changes to the Human Medicines Regulations (2012). This initial project led to further AHP non-medical prescribing proposals, with radiographers, dietetics and paramedics achieving independent and/or supplementary prescribing. The aims of non-medical prescribing are:

- to improve patients' access to treatment and advice;
- to make more effective use of the skills and expertise of groups of professions;
- to improve patient choice and convenience;
- to contribute to more flexible team-working across the National Health Service (NHS).

Prescribing authority by the overarching profession is described in the legislation, whereas the authority given to individual practitioners is effectively delegated to the professional regulator (which for AHPs is the Health and Care Professions Council [HCPC]). The law describes the 'appropriate practitioner' and the need to complete education commensurate to the responsibilities given to the prescriber. The role of the HCPC is therefore to approve education programmes which aspirant prescribers must undertake in order to apply to have their registration annotated. *Annotation* is the evidence of authority and is awarded to the registrant on completion of the education programme to become a prescriber, and exists only while the practitioner has a prescribing role. Where the prescriber changes their role (for example, moving into a leadership role from a clinical role), the annotation should be removed. Annotation can also be removed as part of the usual activities of the regulator, such as the result of a fitness to practice hearing.

Non-medical prescribing is now very well-established and embedded within clinical services across the country. The aims of non-medical prescribing have driven the expansion of prescribing responsibilities to other professions, including paramedics,

and while these achievements are notable for the profession, the basis for prescribing is about safe and timely patient care. Paramedics have a long relationship with medicines, and the granting of independent prescribing co-exists alongside other legal mechanisms that paramedics can access (exemptions and patient group directions) and should enhance the contribution paramedics make in providing the best possible care for patients.

Overview of the Prescribing Mechanisms (Independent and Supplementary Prescribing)

Independent and supplementary prescribing is the most significant medicines mechanism that any healthcare profession can practise using, and responsibility associated with prescribing requires well-developed professional insight. One of the most challenging situations for prescribers which differs from other mechanisms is the autonomy to decide on what and when to prescribe rather than following a protocol. The constant tension between legal, ethical and practical considerations in practice applies to all medicines mechanisms open to paramedics, and highlights the trust in the profession by the establishment and patients.

Box 1.1 – Definitions of independent and supplementary prescribing

Supplementary Prescribing

The main principle of supplementary prescribing is that the patient is already known to the clinical team providing their care, and they have an existing diagnosis. A doctor will have prepared a Clinical Management Plan which lists the medicines intended for the patients care and from which a supplementary prescriber can prescribe.

Independent Prescribing

Independent prescribing is prescribing by a suitable practitioner who can provide holistic care for the patient and develop a care and treatment plan for the patient (within their area of speciality and/or competency) based on the individual aspects required to achieve that, such as physical assessment, diagnostic skills or pharmacological knowledge. Prescribing practice sometimes infers always simply adding more medicines, but in fact reality requires consideration to not prescribe and/or to de-prescribe, as well to prescribe.

Prescribing is a complex undertaking and is made more complex by the nuances of different patient groups and practice settings. Prescribing requires high levels of clinical judgement and the use of the evidence base and practice guidance to inform decisions. For paramedics, the profession has a long relationship with medicines, but its context is very much protocol-driven and based on gross symptomaticity and clinical findings to inform and direct actions. This is therefore often biased towards action, and for prescribers there is a tension between prescribing and

not prescribing (and, indeed, de-prescribing), as is made clear in **Box 1.1**, where definitions are provided. Prescribing as a mechanism, while inferring a pinnacle in the hierarchy, must be seen as the most appropriate mechanism for use, and the other mechanisms should continue to be embraced (for example, using exemptions for resuscitation drugs).

The History of Independent Prescribing by Paramedics

Prescribing by paramedics as a concept originated in 2009 and progressed as far as a ministerial consultation being undertaken and published in 2010 (Department of Health, 2010a). While the consultation report was positive, the project did not progress at that time and was dormant for a number of years. The successful implementation of independent prescribing by physiotherapy and podiatry in 2013 (along with supplementary prescribing by radiographers) led to the expansion of the Allied Health Professions Medicines Programme within NHS England and included the following proposals:

- Use of exemptions by Orthoptists;
- Supplementary prescribing by Dietitians;
- Independent prescribing by Radiographers (expanding their supplementary prescribing status);
- Independent prescribing by Paramedics.

(NHS England, 2015e)

The project began in 2014 and focused initially on building a 'case of need' to describe the outline requirement and to gather sufficient support to seek ministerial approval to undertake a public consultation on the proposals. The case of need was developed and approved by the Medical and Nursing Senior Management Teams within NHS England in May 2014, and the Non-Medical Prescribing Board in the Department of Health in July of the same year. A submission to ministers was made to request the commencement of a public consultation, and this was granted in August 2014. The 12-week consultation period for the radiography and paramedic proposals took place between 26 February and 22 May 2015 (an eight-week consultation period for orthoptists and dietitians was also undertaken) and involved the publication of surveys which could be completed online. A number of engagement events were also held across the UK in the summer of 2015. The consultation for paramedics asked for a preference among five options:

- No change.
- Independent prescribing for any condition from a full formulary.
- Independent prescribing for specified conditions from a specified formulary.
- Independent prescribing for any condition from a specified formulary.
- Independent prescribing for specified conditions from a full formulary.

(NHS England, 2015e)