Education and Training Committee, 10 June 2010

Proposals to introduce prescribing responsibilities for paramedics

Executive summary and recommendations

Introduction

The Department of Health is undertaking a stakeholder engagement exercise to seek views on proposals to extend prescribing responsibilities to paramedics. This includes considering whether paramedics should in future be able to train to become supplementary or independent prescribers.

A copy of the consultation document and the HPC's response are attached for the Committee's information.

Following the outcome of this exercise, the Medicines and Healthcare Products Regulatory Excellence (MHRA) may consult separately on proposals to amend the relevant medicines legislation.

At this stage there is no impact for the HPC. However, if supplementary or independent prescribing was introduced this would have some consequences for the HPC:

- A consultation would need to be held on changes to the standards of proficiency for paramedics to reflect the new entitlement.

- Arrangements would need to be put in place to approve programmes which train paramedics to become supplementary or independent prescribers.

- The registration database and online register would need to be upgraded to allow paramedics who successfully complete the required training to be have their entries in the Register annotated.

The Executive has good contacts with the Department of Health officials working on this project and will keep the Committee updated as appropriate.

Decision

This paper is to note; no decision is required.

Background information

None

Resource implications

None at this time.

Financial implications

None at this time.

Appendices

- Department of Health, ‘Proposals to introduce prescribing responsibilities for paramedics – stakeholder engagement’

- HPC consultation response

Date of paper

27 May 2010

urgent&emergencycare

DH Department of Health

Proposals to introduce prescribing responsibilities for paramedics

Stakeholder engagement

Contents

A: Introduction

What is this engagement exercise?

The ambulance review *Taking Healthcare to the Patient: Transforming NHS Ambulance Services* recommended that prescribing for paramedics should be actively explored.

This engagement exercise sets out the background and options for paramedic prescribing, and invites views from stakeholders on extending prescribing responsibilities to paramedics.

This is not a formal consultation – the Medicines and Healthcare products Regulatory Agency (MHRA) plans to consult formally on proposals for prescribing in due course, drawing on the comments and views from this engagement exercise.

Who is this engagement exercise for?

Everyone is welcome to engage in this exercise. We hope to hear from patients, the ambulance service, providers and commissioners within the wider NHS, pharmacists, regulators, non-medical prescribers, and others.

What would paramedic prescribing mean?

At present, under current medicines legislation, paramedics are able to supply (give out to patients) and administer a range of medicines, on their own initiative, as part of their normal professional practice for the immediate and necessary treatment of sick or injured persons. However, paramedics cannot write a prescription for a patient.

In an emergency situation, it would be unlikely that paramedics would need to write a prescription. Their priority would be to stabilise, treat and transport the patient as necessary. However, only 10% of the cases that paramedics attend are life-threatening emergencies.

Over recent decades, paramedic practice has developed from providing a transport service to sick and injured patients, to providing a broader range of treatment in both emergency and urgent (non-emergency) settings.

Paramedics now treat more patients at their homes, preventing avoidable visits to A&E. Some paramedics also work in settings like Walk-in centres. Paramedics who have undertaken additional training, like Emergency Care Practitioners (ECPs), often work independently in these two types of settings. In broad terms, it is in settings like these, and by advanced paramedics like ECPs, that we would expect paramedic prescribing to be used.

Throughout this document, paramedics who can prescribe will be referred to as Paramedic Independent Prescribers (PARIPs).

> ❛ I had a 72 yr old gent in with a clear case of gout. He needed an anti-inflammatory. I phoned his GP and he was approved for the issue of ibuprofen. The upper age limit for Ibuprofen under a patient group direction (PGD), however, is 65. ❜
>
> Ex-NHS ECP

> ❛ Of ten cases of respiratory tract infection that I audited, seven were not covered by a PGD and so had to rely on others to prescribe. Could have been a lot quicker had the paramedic been able to prescribe. ❜
>
> South Central Ambulance Service ECP

❛ We get many patients who are travelling through or on holiday, and who have forgotten or ran out of medication, most commonly asthma inhalers. I have to advise them to call the out of hours GP services if no prescriber is on duty, as the PGD limits issue of inhalers or immediate brochodilators to patients actually having asthma attacks. ❜

Ex-NHS ECP

❛ Increasing antibiotic resistance requires a flexible and targeted response utilising advice from the health protection agency. The inflexible and rigid confines of PGDs do not allow the practitioner to adapt pharmacological interventions without considerable delay; creating a reactionary service. ❜

South Western Ambulance Service ECP

❛ Being able to prescribe would allow me to work in a GP practice as an advanced practitioner as well as most walk in centres, out of hours clinics or A and E departments. This is of course what the emergency care practitioner scheme initially set out to achieve, however the practicalities of independent prescribing make this difficult. ❜

Ex-NHS ECP

❛ Nurse practitioners [in my area] are utilised to carry out home visits using their prescribing. There are no PGDs, however, so I would be excluded from carrying out this type of work even though it is exactly the same job as I did when employed with the ambulance service. ❜

Ex-NHS ECP

The wider context – urgent and emergency care

The ambulance service cannot be seen in isolation from wider urgent and emergency care services. These include A&E, in and out of hours primary care, walk-in centres and minor injuries units, NHS Direct, and community services such as falls teams and district nursing teams.

The Department of Health's vision for urgent and emergency care is that patients are provided with 24/7 services which are integrated together, so that patients get the right care wherever they access the health system, and do not have to 'tell their story' multiple times to different services as they move through the system. Achieving better integration in urgent and emergency care will mean better patient care and more productive, effective NHS services.

The ambulance service is developing within this context. In particular, the flexible roles undertaken by ECPs and other advanced practitioners in delivering care to patients at home and in the community, require good cooperation between the ambulance service and other health professionals working with the patient, including the GP.

Prescribing by paramedics could support better integration of urgent and emergency care services. If a patient can be given the prescription they need by a paramedic, this avoids the patient needing to make an additional visit to another healthcare provider.

Prescribing by nurses, pharmacists and optometrists

Over recent years, non-medical prescribing has been extended to a number of other professions, including nurses, pharmacists and optometrists.

There are now over 15,000 qualified nurse independent prescribers and around 1000 qualified pharmacist independent prescribers. While paramedics have a different role to nurses and pharmacists, we would like to learn from the experience of extending prescribing to these non-medical professions. Evidence from evaluation of nurse prescribing in 2005 and an ongoing evaluation of nurse and pharmacist prescribing indicates that such prescribing is valued by patients and gives them quicker access to the medicines that they need.

Timing

This request for views remains open for 12 weeks, and will close on Friday 11 June. Responses should be sent to **urgent&emergencycare@dh.gsi.gov.uk**. A postal address for written comments can be found in Section G. A summary of the engagement exercise questions can be found at Schedule 1. Additional comments are welcome and will be considered carefully.

Next steps: formal consultation by the MHRA

Taking account of the views gathered in this engagement exercise, the MHRA plans, in due course, to consult formally on:

- Whether there is a case for extending prescribing responsibilities to paramedics
- If so, whether any restrictions should be placed on prescribing in terms of the medical conditions that can be prescribed for and / or the range of medicines that might be prescribed
- Who should be allowed to prescribe

B. Benefits, risks and principles of paramedic prescribing

This part of the engagement exercise sets out some of the key benefits and risks of extending prescribing responsibilities to paramedics, and asks for views on a set of principles that have been developed based on learning from the extension of prescribing responsibilities to other health professionals.

Key benefits

Improved individual patient experience

Patients who need certain prescriptions could, where appropriate and with the right information sharing processes in place, obtain it from a qualified paramedic prescriber, instead of having to make a separate appointment with another health professional.

This would be more convenient for the patient. They would not have to repeat their story to another health professional in a second episode of care for the same problem.

Improved service for patients through more productive NHS services

Reducing the need for patients to attend an additional appointment to get a prescription means more productive use of NHS services and resources, e.g. through reducing the need for patients to have a follow up primary care appointment after seeing a paramedic.

Extending prescribing to some paramedics would mean making better use of the range and flexibility of the NHS workforce to help give patients the best possible service.

Key risks

There are risks inherent in any prescribing, and the risks in relation to paramedic prescribing would need to be addressed through robust safeguards. These are covered in more detail in the section on Safeguards (Section E, page 25), but the two most important risks are:

- the risk to patient safety of inappropriate prescribing of medicines; and
- the risk to patient safety of failure to share information e.g. if the patient's GP was not made aware of a prescription being given to a patient

Principles underlying prescribing responsibilities

- **Patient safety** is paramount. Prescribing responsibilities should only be extended when this will deliver safer and more convenient care for patients
- Prescribers should only prescribe and practice **within the limits of their clinical competence**
- Prescribing must be underpinned by robust **clinical governance**
- Independent prescribers must take full **clinical and professional responsibility** for their decisions. Prescribers must be able to recognise when they need to ask for support in relation to a patient's care
- **Commissioning** of prescribing services should be determined by the needs of patients and the NHS locally
- **Training** should be defined locally, within a nationally agreed outline curriculum for prescribing training
- Dispensing pharmacists and those charged with prescription reimbursement need to be able to **easily identify** those who are entitled to prescribe, and any constraints within which the individual can prescribe

Question:

Do you agree with these principles? Are there other principles that should be included here?

FEEDBACK

C: Eligibility and training

This part of the engagement exercise asks for views on which paramedics would be eligible to become prescribers, and what training would be needed for Paramedic Independent Prescribers (PARIPs).

Paramedic roles

Paramedics are the senior ambulance service healthcare professionals who respond to 999 calls. Generally working with an emergency care assistant (ECA) or emergency medical technician (EMT), they assess the patient's condition and provide essential treatment at the scene. Paramedics are trained to resuscitate and/or stabilise patients using sophisticated techniques, equipment and drugs, and work closely with doctors and nurses in hospital accident and emergency departments.

The evolution of the paramedic role has included the introduction of the emergency care practitioner (ECP) and other similar roles. ECPs are paramedics who have developed their skills beyond those of the traditional paramedic. ECPs often work independently, treating patients at their homes or in community settings such as walk-in centres.

As set out in the introduction, it is not expected that paramedics would need to prescribe (ie write a prescription for dispensing in a commmunity pharmacy) when they attend emergency calls. Prescribing would be used by the most advanced paramedics, such as ECPs, in their urgent (non-emergency) care roles, treating patients at their homes and in the community.

It is expected that the most advanced level paramedics, such as ECPs will be eligible to undertake training to be able to prescribe. There were, by 30 September 2008 (latest validated data), just over 700[1] ECPs in England. Others may have been appointed since then, but it is not expected that this will represent a large increase. Not all of these would be expected to apply to become prescribers.

1 ECP Headcount, NHS Hospital and Community Health Services, Non-Medical Staff, England 2008; NHS Information Centre for Health and Social Care

Eligibility

It is proposed that paramedics eligible to apply for independent prescribing courses should be able to demonstrate:

- Having operated at Level 7 of the Skills for Health Careers Framework (See Schedule 2 for more details)
- The ability to train to degree equivalent level;
- 3 years post registration experience as a paramedic; and
- At least 1 year practicing as a practitioner in the required field, e.g. as an ECP or other form of paramedic that meets the necessary criteria (this would need to be assessed carefully, as ECPs and other paramedics in similar roles may have a wide variety of differing experience, different amounts of experience working in urgent as opposed to emergency care settings, etc.)

They would also be expected to be able to:

- Take an effective patient history
- Further assess a patient by a general or focused physical examination
- Undertake basic observations and investigations
- Reach a working diagnosis
- Refer where necessary for more specialist opinion or investigation
- Intervene pharmacologically where necessary to complete and resolve a consultation
- Be able to recognise the risks of poly-pharmacy (where a patient is taking multiple different medications that may interact with one another)

Private Sector Paramedics

In line with current arrangements for other non-medical prescribers, any paramedic, whether working in the NHS or the private sector, that meets agreed eligibility criteria should be able to apply for the relevant courses.

To protect patient safety, entry to prescribing training courses could be restricted to paramedics employed by organisations registered with the Care Quality Commission (CQC). This would ensure that NHS paramedics, as well as any employed by other registered employers who have demonstrated to the CQC that they have acceptable governance structures and safeguards in place, would be eligible to apply if they meet the other criteria. It would, however, exclude any paramedics whose organisations fail to deliver the necessary assurances.

Question:

Should entry to prescribing courses be restricted to paramedics employed by organisations registered with the CQC?

FEEDBACK

Training

Current training arrangements

The Health Professions Council (HPC) approves paramedic training programmes which are delivered by over 20 Higher Education (HE) institutions and by NHS ambulance trust training centres. Since 2007 all newly qualified paramedics are required to have HPC training, and a number of existing paramedics are retrospectively attaining HE qualifications.

ECP training is based on the approved Skills for Health Curriculum and Competency Framework and is tailored by individual trusts to meet the needs of their local communities.

Prescribing training for PARIPs

The Health Professions Council also approves higher education institution courses for prescribing training. Training for prescribing in the NHS generally is commissioned and funded through the SHAs' multi-professional education and training budgets (and their equivalents in the devolved administrations). It is expected that any new courses for PARIPs would be commissioned and funded in the same way.

Currently, multi-disciplinary HPC-approved courses are available for physiotherapists, podiatrists and radiographers who need to qualify as supplementary prescribers (see Section D, page 18, for more information about supplementary prescribing). If the decision is taken to proceed with independent prescribing for paramedics, these courses might be adapted to allow paramedics to train to become independent prescribers. The HPC could then approve these courses .

Although the courses would be accredited by the HPC, employers would still be responsible for ensuring that arrangements were in place to ensure that individual paramedics had the appropriate skills and expertise to prescribe effectively and safely before (and following) attendance on a prescribing training course.

Annotation of the HPC register

The HPC annotates its registers for staff who have completed the relevant approved prescribing training course. Once qualified as a PARIP, prescribing would become part of a paramedic's continuing education and training requirements, and they would be expected to demonstrate that prescribing skills and competencies would be maintained (CPD is considered in more detail under Safeguards, Section E, page 25). The HPC would need to amend its own Professional Standards to accommodate this change.

Question:

Do you agree with the proposed entry criteria for training for independent prescribing responsibilities? If not, what would you change?

FEEDBACK

D: Paramedic prescribing: the options

This part of the engagement exercise sets out in more detail how, in practical terms, prescribing for paramedics could work, and asks for views and comments.

The options are:

1 No change, continuing to use Patient Group Directions (PGDs), Patient Specific Directions (PSDs) and Exemptions for supply and/or administration of medicines

2 Supplementary prescribing

3 Prescribing for specified conditions from a specified formulary of medicines

4 Prescribing for any condition from a specified formulary

5 Prescribing for specific medical conditions from a full formulary (within competence)

6 Prescribing for any condition from a full formulary (within competence)

This section also asks for views on whether PARIPs should be able to prescribe controlled drugs.

Option 1: No change, continuing to use Patient Group Directions (PGDs), Patient Specific Directions (PSDs) and Exemptions

Under this option, paramedics would continue to use the tools currently at their disposal – PGDs, PSDs and exemptions – to supply and/or administer medicines to patients, but would not be able to prescribe.

What are PGDs, PSDs, and Exemptions?

A Patient Group Direction (PGD) is a written instruction for the sale, supply and/or administration of named medicines in an identified clinical situation. It applies to groups of patients, not to individuals. Since 2003, a limited number of controlled drugs have been added to the medicines that may be administered and/or supplied in accordance with a PGD.

A Patient Specific Direction (PSD) is a written instruction from a doctor, non-medical prescriber or a dentist that allows a medicine to be supplied or administered to a named patient.

Exemptions are specific orders exempting certain professionals from the Prescription Only Medicines (POMs) legislation for supply and/or administration of specified medicines.

Benefits of Option 1

The use of PGDs, PSDs and Exemptions by paramedics currently means that they are able to administer a range of medicines to patients. PSDs can help to provide continuity of care by alerting paramedics to a patient's care plan and medical history.

Limitations of Option 1

While PGDs, PSDs and Exemptions mean that paramedics are able to administer medication to treat a wide range of conditions, paramedics are currently not able to write a prescription for a patient. This means that patients may have to attend an additional appointment to get a prescription from another health professional.

Option 2: Supplementary prescribing

Supplementary prescribing is a voluntary partnership between an independent prescriber (a doctor or dentist) and a supplementary prescriber to implement a patient-specific clinical management plan (CMP), with the patient's agreement. The patient normally returns for review to the supplementary prescriber rather then the independent prescriber.

Benefits of Option 2

This is a possible alternative to full independent prescribing by paramedics. It was initially implemented for pharmacists before full independent prescribing responsibilities were extended to them. It is more suited to patients who need long-term or continuing care.

Limitations of Option 2

This would be a very limited option and would probably benefit only those patients attending a clinic where a paramedic is working under the supervision of an doctor. It would not be practical for paramedics travelling to patients' homes in response to (non-emergency) 999 calls.

Option 3: Prescribing for specified conditions from a specified formulary

Under this option, PARIPs would be able to write prescriptions for patients that had one of a list of specific conditions, and the medicines they could prescribe would be from a limited list (or formulary) of medicines. The National Out-of-hours Formulary Core Drug List **www.ppa.org.uk/edt/ March_2010/mindex.htm**) could be used for this purpose, although thoughts on alternatives would be welcome.

Benefits of Option 3

This option could benefit patients with particular conditions. Patients with a well-defined condition could benefit from this option provided the relevant medicines are on the specified formulary.

Limitations of Option 3

This option could prevent patients with conditions that are not on the specified list from benefitting from being able to receive a prescription from a paramedic, even though this may be safe and appropriate. Patients with a condition that was on the list might not be able to receive a prescription from the paramedic if the appropriate medication was not on the specific list.

To meet emerging needs in patient care, the list of medicines is likely to need updating relatively often. As changes to the formulary would require a legislative process each time, the process would not be able to be responsive to changing patient needs and developments in clinical practice by PARIPs in a timely way.

Option 4:
Prescribing for any condition from a specified formulary

Under this option, PARIPs would be able to write prescriptions for patients with any condition, using medicines from a formulary. As with Option 3, the National Out-of-hours Formulary Core Drugs List (**www.ppa.org.uk/edt/ March_2010/mindex.htm**) or another appropriate formulary could be used for this purpose.

Benefits of Option 4

A wider range of patients could benefit from this option compared to Option 3.

Limitations of Option 4

PARIPs may be in a position where they could safely prescribe a medication within their competence, but cannot do so because it is not on the limited formulary list, meaning that the patient has to make an additional appointment to get the prescription.

As with Option 3, any changes to the formulary list would need to be made via a legislative process, which means that the process would not be able to be responsive to changing patient needs and developments in clinical practice by PARIPs in a timely way.

Option 5: Prescribing for specific medical conditions from a full formulary (within competence)

This option is the opposite of Option 4, limiting the conditions that an PARIP could prescribe for but allowing them to prescribe from a full formulary of medicines, within their clinical competence. The list of conditions would need to be defined.

Benefits of Option 5

As with option 3, this option would be likely to benefit more patients, particularly those with long term conditions with a well-defined care plan. Having the scope to prescribe a wider range of medicines could enable PARIPs to treat more patients, for example those whose usual medication is not on the specified formulary list, and where the PARIP assesses their condition as not needing an additional GP authorisation.

Limitations of Option 5

PARIPs may be in a position where they could safely prescribe a medication, but cannot do so because the patient's condition is not on the list of medical conditions, meaning that the patient has to make an additional appointment to get the prescription.

Any changes to the specified list of patient conditions would require (non-legislative) amendments that could mean that this option could be seen as unnecessarily bureaucratic.

Option 6: Prescribing for any condition from a full formulary (within competence)

This option would be closest to what nurses and pharmacists can train to do. Under this option, PARIPs would work within their clinical competence to prescribe medication to patients, without limits on either the conditions they could prescribe for or the list of medicines they could prescribe.

Benefits of Option 6

This option would enable the maximum number of patients who could potentially benefit from paramedic prescribing to do so. Under this option, the responsibility for prescribing within competence would be very clearly with the PARIP themselves. Further legislation would not be needed to amend lists.

Limitations of Option 6

This option would include the most risk, and would need to be accompanied by robust clinical governance and safeguards to ensure that PARIPs operate within their competences and adhere strictly to training and CPD requirements.

Learning from nurse and pharmacist independent prescribing, which is based on prescribing within competency, should be drawn on if this option is chosen.

Question:

Which of the above options (1-6) do you think would be most likely to add the most value to patient care, while ensuring risks are kept to acceptable, and manageable, levels?

FEEDBACK

Question:

If you prefer Option 3 or 4, would the proposed National Out of Hours Formulary Core Drug List serve that purpose, or would an alternative list of medicines be preferable?

FEEDBACK

Controlled drugs

Controlled medicines are prescription medicines that contain drugs that are controlled under the Misuse of Drugs legislation. Examples include benzodiazepine morphine, pethidine and methadone. They are classified by law based on their benefit when used in medical treatment and their harm if misused.

Paramedics are able to administer a number of controlled drugs using PGDs and exemptions. If prescribing responsibilities are extended to paramedics, it will need to be decided whether PARIPs should be able to prescribe controlled drugs. If so, amendments would need to be made to specific legislation governing controlled drugs (the Home Office's Misuse of Drugs Regulations).

Patients are unlikely to need a written prescription for controlled drugs within the type of situations where they are attended by paramedics, but there could be benefit for PARIPs being able to prescribe some of the more common pain-killers (eg, codeine) which are controlled drugs.

Question:

Would there be benefit to patients of PARIPs being able to prescribe controlled drugs? If so, in what circumstances?

FEEDBACK

E: Safeguards

This part of the engagement exercise looks at the safeguards that would be needed to protect patients if prescribing responsibilities were extended to paramedics, and invites comments on these and any other safeguards that would be required.

Clinical governance

There is a risk around insufficently robust clinical governance arrangements being in place. Employers would be responsible for ensuring that appropriate clinical governance measures were in place to protect patient safety. This may include clinical supervision arrangements, regular audit of individual practice, robust risk management strategies, and policies for reporting and investigating errors.

Continuous Professional Development (CPD)

There is also a risk around inadequate CPD arrangments being in place to ensure PARIPs maintain the necessary skill levels. PARIPs would need to be confident that their initial assessment and diagnosis of the patient was precise, so that any decision to prescribe was based on accurate information and was safe. In particular, if faced with a rare or unfamiliar condition, referral to a doctor will be the best course. PARIPs would need to be confident that their skills were up to date and relevant enough to enable them to prescribe medication for the patient safely, including where patients are taking multiple medications. CPD would be key to ensuring those skills were maintained.

All qualified prescribers have a professional responsibility to keep themselves up to date with clinical and professional developments. The HPC has stipulated CPD requirements, and expects all prescribers to meet the necessary standards as and when checks are made. HPC undertake a 2.5% random sample audit to ensure that its registrants are keeping up-to-date and meeting its standards for CPD.

We would welcome views on whether these arrangements are robust enough to ensure all PARIPs remain up to date with the latest developments and able to prescribe competently and safely.

Access to the patient's medical history

Access to a patient's records would normally be standard procedure before any prescribing, but this may not always be feasible for a prescriber in an urgent care or out-of-hours context. Remote access to patients' Summary Care Record may, within the coming years, enable PARIPs to view a patient's medical history using mobile technology. In the meantime, a PARIP in the community would be expected to undertake a thorough assessment of the patient's history, presenting condition and current medications before considering prescribing. If the details of a patient's medications were not available, it would be the responsibility of the PARIP to make contact with the patient's GP (or other health professional, such as a district nurse where appropriate) to get that information before writing a prescription.

This is an issue already faced by most prescribers as well as many paramedics. When administering medicines to patients through PGDs or exemptions, paramedics rarely have access to comprehensive medical records, and have to get information from the patient, and/or contact other health professionals before treating the patient.

Sharing information

Nurse prescribers are currently expected to update a patient's notes contemporaneously if possible and in any event within 48 hours of the episode of care, so that other healthcare professionals involved in the patient's care have up to date information about the patient's medication. It is anticipated that PARIPs would be expected to conform to the same principle.

This may be done electronically where possible, via an email or electronic update to the GP's office where the patient's notes are held, or by fax to the GP's surgery where electronic technology is not available.

Abuse of paramedic prescribing

There could be some potential for abuse of paramedic prescribing, under the different options that have been set out, both by patients and by paramedics.

A very small number of patients may see an opportunity to manipulate paramedics to prescribe them drugs that their GP or another health professional did not wish them to have. This risk would need to be mitigated by communication between PARIPs and other healthcare professionals involved in the care of the patient, and careful scrutiny of a patient's history by the PARIP.

Employers, backed by the regulator, would be responsible for identifying and tackling abuses of prescribing as they are for current prescribers.

Question:

Would the safeguards proposed, if properly implemented, be sufficient to protect patients from the range of risks associated with prescribing responsibilities being assigned to PARIPs?

If not, what other risks do you envisage, and what other safeguards would be required to maintain patient safety and levels of care?

FEEDBACK

Question:

In terms of sharing knowledge and updating records, are the arrangements proposed sufficient to ensure that PARIPs have the information they need ahead of issuing prescriptions on site, and to ensure records are updated for those following on behind?

If not, what else is required?

FEEDBACK

F: Implementation

Regulatory changes

Nationally, the medicines regulations – the Prescription Only Medicines (POM) Order – and NHS regulations would need to be amended to enable prescribing by PARIPs.

In terms of implementing the changes locally, NHS bodies would themselves be responsible for introducing independent prescribing by paramedics within their own organisations. In doing so, it is expected that they will take into account the needs of their population, safety issues and resource implications.

Devolved administrations

Any proposed changes to the POM order would apply throughout the United Kingdom, both in the NHS and in the private and voluntary sectors. Each of the four UK countries will determine the most appropriate approach and whether to amend their NHS regulations to support this initiative in line with their own health policies and NHS systems.

Provisional assessment of costs, benefits and equality impacts

The key benefits of extending prescribing responsibilities to paramedics include the improved patient experience and clinical outcomes from obtaining access to medicines with reduced delays, and the improved convenience for patients and productivity gains from reducing multiple healthcare appointments for the same presenting condition. There may also be positive equality impacts, relating to meeting the needs of patients who have limited mobility.

There would be no obligation for the NHS to introduce paramedic prescribing, and it would be for commissioners and providers locally to decide whether it would most benefit their populations. The key costs of the proposals are the training costs for prescribing courses (currently estimated at approximately £350,000[1]), and administrative costs for the HPC to amend their registration system and consult on the threshold standards of proficiency relating to prescribing entitlements (estimated at £20,000 to £25,000).

A full impact assessment (IA) and equality impact assessment (EqIA) will accompany the formal consultation exercise for these proposals. Any comments and information that will help refine the estimates of the cost-effectiveness and equality impact of these proposals are welcome, particularly looking at the different costs and benefits associated with Options 1 – 6 in Section D of this document.

Training and Related Costs

Training for prescribing in the NHS is funded and commissioned by SHAs in England (and by their equivalents in the devolved administrations).

Whether individuals are put forward for prescribing training is a matter for the trust and the paramedic to agree, and there is no obligation for paramedics to become prescribers. The cost of prescribing training would therefore be on a voluntary basis.

Estimates calculated as part of a recent Allied Health Professions (AHP) prescribing scoping project, looking at the potential introduction of prescribing responsibilities for other designated AHPs, concluded that the training costs for those that did opt to undertake the training would be comparatively small, at around £1,200 per head, per course.

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1 £350,000 is a rounded estimate dervied from:
- Estimated headcount of 900 Emergency Care Practitioners in 2011 (derived from NHS non-medical workforce bulletin, 2008)
- Estimated proportion of one-third of Emergency Care Practitioners who will opt for prescribing training (London Ambulance Service, personal correspondence Jan 2010)
- Estimated average cost per participant of £1,200 for prescribing training courses (Allied Health Professionals Prescribing Scoping Project)
- Assume full uptake of prescribing training by first tranche of eligible paramedics

These figures are based on existing courses and, as the HPC should be able to adapt and utilise the current prescribing courses to enable paramedics to qualify as PARIPs, any course development costs would also be expected to be minimal. There could also be some costs to trusts associated with the time needed to release paramedics to attend prescribing training courses, as well as the cost of providing medical supervision to the PARIP.

Question:

Can you offer any information about potential costs and benefits of paramedic prescribing for the impact assessment, e.g. benefits in terms of time savings to GPs, costs relating to the number of paramedics likely to go forward for training, or any other factors?

FEEDBACK

Question:

Can you offer any information on how these proposals would impact on equality in your local area, particularly concerning disability, ethnicity, gender, sexual orientation, age, religion or belief, and human rights? Could any group be excluded or better included because of the policy, and will the policy present or remove any problems or barriers to any minority group?

FEEDBACK

Question:

Are there any other implications for implementing prescribing for paramedics?

FEEDBACK

G: Schedules

Schedule 1 – Summary of questions

Click here to complete the online feedback form to submit your responses.

If you would prefer, please print the form and:

Either Fax to:

FAO Nick Crowther
The Urgent & Emergency Care Team
Department of Health
Fax: 0207 633 4054

Or Send to:

FAO Nick Crowther
The Urgent & Emergency Care Team
Department of Heath
11th Floor
New Kings Beam House
22 Upper Ground
London SE1 9BW

Schedule 2 – Skills for Health Careers Framework – level 7

1. Knowledge, Skills, Training and Experience – Utilises highly developed specialised knowledge covering a range of procedures and underpinned by relevant broad based knowledge, experience and competence AND develops new skills in response to emerging knowledge and techniques. OR Uses highly specialised theoretical and practical knowledge some of which is at the forefront of knowledge in the work area. This knowledge forms the basis for originality in developing and/or applying ideas AND develops new skills in response to emerging knowledge and techniques. OR Demonstrates critical awareness of knowledge issues in the work area and at the interface between different work areas, creating research based diagnosis to address problems by integrating knowledge ANDMaking judgements with incomplete or limited information, and developing new skills in response to emerging knowledge and techniques.

2. Supervision – Demonstrates leadership and innovation in work contexts that are unfamiliar, complex and unpredictable and that require solving problems involving many interacting factors. ORReviews strategic impact/outcome of the work.

3. Professional and vocational competence – Demonstrates independence in the direction of practice and a high level understanding of development processes AND responds to social/scientific, clinical/ethical issues that are encountered in work or study AND manages change within a complex environment. OR Demonstrates independence in the direction of practice responding to social scientific clinical and ethical issues that are encountered in work or study AND High level understanding of development processes. OR Demonstrates independence in the direction of practice responding to social scientific clinical and ethical issues that are encountered in work or study AND Solves problems by integrating complex knowledge sources that are sometimes incomplete and in new and unfamiliar contexts. ORDemonstrates independence in the direction of practice responding to social scientific clinical and ethical issues that are encountered in work or study AND Manages change within a complex environment.

4. Analytical / Clinical Skills and Patient Care – Provides highly specialist clinical, technical and/or scientific services AND makes complex judgements. OR Provides specialist clinical, technical and/or scientific services across a work area AND makes complex judgements. OR Accountable for direct delivery of part of service AND makes complex judgements.

5. Organisational Skills and Autonomy/Freedom to Act – Responsible for work area, specialist services or clinical pathways OR Accountable for direct delivery of part of service.

6. Planning, Policy and Service Development – Proposes changes to practices or procedures which impact beyond own work area OR May plan and/or organise a broad range of complex activities or programmes with formulation of strategies.

7. Financial, Administration, Physical and Human Resources – Devise training or development programmes. OR Responsible for work area budget. OR Manages staff and/or services ranging in size and complexity.

8. Research and Development – Initiate and develop R&D programmes.

More information is available at the Skills for Health Website:

http://www.skillsforhealth.org.uk/workforce-design-development/workforce-design-and-planning/tools-and-methodologies/career-frameworks.aspx

Schedule 3 – Sources

Members of the DH Paramedic Prescribing Reference Group

Taking Healthcare to the Patient, Transforming NHS Ambulance Sevices, DH, June 2005

Supplementary Prescribing by Nurses, Pharmacists, Chirpodists/Podiatrists, Physiotherapists and Radiographers with the NHS in England, A Guide to Implementation, DH, Updated May 2005

Consultation on Proposals to Introduce Independent Prescribing by Pharmacists, MHRA, March 2005

Consultation on Proposals to Introduce Independent Prescribing by Optometrists, MHRA, August 2006

Consultation on Options for the Future of Independent Prescribing by Extended Formulary Nurse Prescribers, MHRA, February 2005

Clinical Evidence in Support of the Business Case for Independent Prescribing for Advanced Paramedic Practitioners, Chris Carney MB.BS.FIMC.RCSEd, April 2008

Allied Health Professions Prescribing and Medicines Supply Mechanisms Scoping Paper and Report, DH, July 2009

The NHS Information Centre for Health and Social Care Skills for Health Careers Framework

NHS Careers

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning / Performance	Finance
	Social Care / Partnership Working

Document Purpose	Consultation/Discussion
Gateway Reference	13665
Title	Proposals to introduce prescribing responsibilities for paramedics – a stakeholder engagement
Author	Nick Crowther
Publication Date	22 Mar 2010
Target Audience	NHS Trust CEs, PCT CEs, SHA CEs, Medical Directors, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Emergency Care Leads
Circulation List	
Description	The Department will consider all responses to the stakeholder engagement exercise. These will help to shape a formal consultation planned for later in the year, which will ultimately inform recommendations to Government Ministers on whether to extend prescribing to paramedics.
Cross Ref	N/A
Superseded Docs	N/A
Action Required	N/A
Timing	Engagement exercise ends on 11 June 2010
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For Recipient's Use	

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20 April 2010

Health Professions Council response to Department of Health consultation 'Proposals to introduce prescribing responsibilities for paramedics'

The Health Professions Council welcomes the opportunity to respond to this consultation.

The Health Professions Council is a statutory UK wide regulator of healthcare professionals governed by the Health Professions Order 2001. We regulate the members of 15 professions. We maintain a register of professionals, set standards for entry to our register, approve education and training programmes for registration and deal with concerns where a professional may not be fit to practise. Our main role is to protect the health and wellbeing of those who use or need to use our registrants' services.

We have answered the consultation questions relevant to our role as the statutory regulator of paramedics.

Questions

1. Do you agree with these principles [for prescribing]? Are there any other principles that should be included here?

We agree with the principles which we consider to be appropriate and comprehensive.

2. Should entry to prescribing courses by restricted to paramedics employed by organisations registered with the CQC?

The proposal to restrict entry to prescribing courses to paramedics employed by organisations registered with the CQC seems to be reasonable and appropriate in that this would provide additional safeguards.

3. Do you agree with the proposed entry criteria for training for independent prescribing responsibilities?

We agree with the proposed entry criteria for training for independent prescribing responsibilities.

4. Which of the options below (1-6) do you think would be most likely to add the most value to patient care, while ensuring risks are kept to acceptable, and manageable, levels?

1. No change, continuing to use PGDs [Patient Group Directions], PSDs [Patient Specific Directions] and Exemptions

2. Supplementary Prescribing

3. Prescribing for specified conditions from a specified formulary

4. Prescribing for any condition from a specified formulary

5. Prescribing for specific medical conditions from a full formulary (within competence)

6. Prescribing for any condition from a full formulary (within competence)

We have not commented on this question directly as we believe that the appropriate form of independent prescribing which should be introduced for paramedics is a matter for others such as service providers, the medicines regulator, the Medicines and Healthcare Products Regulatory Agency (MHRA), the Department of Health and the profession itself to determine.

However, we feel that it is important to emphasise that professional regulation is in no way an impediment to extending the scope of independent prescribing rights. Whichever option is chosen, professional regulation will ensure that appropriate standards are in place for practitioners and that the public remains protected.

In particular, all registrants, including those with prescribing rights, are required to practise safely and effectively within their scope of practice and to only undertake additional tasks where they have the requisite education, training and experience. They are also expected to refer to other professionals where appropriate.

The consultation document points out that some of the options may lead to updating the list of available medicines or conditions relatively recently. It might be helpful to bear in mind that such an approach might also have consequences for our approval of programmes. If substantive changes were made to the list of medicines or conditions which necessitated major changes to these programmes we would need to consider these under our approval and monitoring processes.

8. Would the safeguards proposed, if properly implemented, be sufficient to protect patients from the range of risks associated with prescribing responsibilities being assigned to PARIPs?

We consider that the safeguards outlined in the consultation document are likely to be sufficient to protect patients from the range of risks associated with prescribing responsibilities being assigned to Paramedic Independent Prescribers (PARIPs). In particular, robust clinical governance arrangements to ensure good prescribing practice are essential.

With regards CPD, as stated in the document, all paramedics are required to undertake CPD which meets our published standards for continuing professional development. These standards are outcomes-focussed, and require registrants to seek to undertake CPD which benefits service delivery and service users. An audit is conducted of each profession every two years, with 2.5% of the profession currently being sampled.

These arrangements do provide additional safeguards. However, it is important to note that our CPD standards are generic requirements so do not make specific requirements about CPD in subjects allied to prescribing. It would be important for paramedics with prescribing responsibilities to have access to prescribing-specific CPD opportunities in the workplace.

In addition to the safeguards listed, the normal arrangements put in place when prescribing is extended also act as a safeguard to protect the public. The Prescription Only Medicines (Human Use) Order 1997 is normally amended so that only someone from a specified profession can undertake the specified prescribing activities and that they must have their names annotated on the relevant professional Register. This in effect ensures that the function of prescribing is limited, not to only to a registrant, but to those who have undertaken appropriate training in order to have their entry in the Register annotated. For example, chiropodists and podiatrists who have undertaken appropriate training in order to administer local anaesthetics will have their entries in the HPC Register annotated. Only those chiropodists and podiatrists with the annotation are able to legally administer local anaesthetics from the relevant exemption list.

10.1 Can you offer any information about potential costs and benefits of paramedic prescribing for the impact assessment, e.g. benefits in terms of time savings to GPs, costs relating to the number of paramedics likely to go forward for training, or any other factors?

Please see 10.3 for an outline of the steps we would need to undertake if prescribing options 2-5 outlined in the document were to be implemented.

The paragraph at the top of page 31 reads: 'These figures are based on existing courses and, as the HPC should be able to adapt and utilise the current prescribing courses to enable paramedics to qualify as PARIPs, any course development would also be expected to be minimal.'

It is important to note that HPC is involved in approving programmes which lead to entry to, or annotation of, the HPC Register. We would not 'adapt and utilise' current prescribing programmes ourselves - whether such programmes are opened up to paramedics is a matter for commissioners, education providers and market demand. However, we would be involved in approving such programmes.

For example, we currently approve supplementary programmes which allow radiographers, chiropodists / podiatrists and physiotherapists to become supplementary prescribers. If supplementary prescribing was to be introduced for paramedics education providers might adapt their programmes to allow entry by paramedics and seek approval from us. As we already approve these programmes for other HPC registered professions and the standards are likely to

be same, we might potentially be able to deal with such a change via our major change process rather than requiring a full approval visit of the programme.

If existing programmes which currently allow nurses and pharmacists to become independent prescribers were adapted to allow entry by paramedics, the education provider would need to seek HPC approval of the programme. As for HPC purposes this would be a new programme, we would need to undertake a full approvals visit to determine whether the programme met our standards.

Education providers would need to be in receipt of HPC approval prior to paramedics commencing programmes.

10.3 Are there any other implications for implementing prescribing for paramedics?

As we stated in relation to question 4.2, professional regulation is not a barrier to extending prescribing. However, we thought that it might be helpful to lay out the steps that the HPC would need to take should independent prescribing rights be extended to paramedics

There would be no implications if option 1 (no change) was adopted. Options 2 to 5 involve introducing supplementary prescribing or various forms of independent prescribing, each of which would involve specific education and training and annotation of a practitioner in the HPC Register.

If a decision was made to introduce supplementary or independent prescribing we would need to amend the standards of proficiency for paramedics to add a standard or standards relating to the new entitlement. For example, the standards of proficiency for radiographers, currently read: 'know and be able to apply the key concepts which are relevant to safe and effective practice as supplementary prescriber (this standards applies only to registrants who are eligible to have their names annotated on the Register)'. We would need to consult for three months before making any changes to the standards.

Once these standards are in place we would then be able to approve programmes to allow paramedics to become supplementary or independent prescribers. If a full approval visit was required (for example, if independent prescribing programmes for nurses and pharmacists were extended to paramedics), we would require 6 months notice of the visit followed by up to 3 months post-visit for the education provider to meet any conditions and for approval to be confirmed. If the supplementary prescribing programmes we already approve for chiropodists / podiatrists, physiotherapists and radiographers were adapted for paramedics we may be able to deal with this under our major change process which might truncate the likely timescales involved. A programme would need to be in receipt of HPC approval prior to the first cohort of paramedics commencing the programme. A paramedic completing an approved programme would then have their entry in the Register annotated.

Finally, our experience of approving supplementary prescribing programmes has been that the number of places available on programmes has sometimes exceeded demand, meaning that some programmes have not been delivered to HPC cohorts in some years. This has raised questions around our ability to ensure that those programmes continue to meet our standards for cohorts in

future years. An incremental approach to commissioning programmes might be helpful here.

We hope you have found our comments useful. If you have any questions, please contact us.

Yours sincerely,

Michael Guthrie
Director of Policy and Standards

[Submitted using Department of Health consultation form]