

# **Improving Patients' Access to Medicines: A Guide to Implementing Paramedic Prescribing within the NHS in the UK.**

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# Improving Patients’ Access to Medicines: A Guide to Implementing Paramedic Prescribing within the NHS in the UK.

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## Document Control

This document has been adapted for the NHS England Allied Health Professions Medicines Project by the College of Paramedics and is based on the original document published by the Department of Health in 2006 which supports Nurse and Pharmacist independent prescribing, with their consent. References to versions and authors from here on should be viewed in consideration of the original document.

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A Guide to Implementing Paramedic Prescribing  
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## Introduction

This guide sets out the administrative and procedural steps needed to enable advanced paramedics in the UK to act as independent and supplementary prescribers. It provides information and advice on good practice in the implementation of advanced paramedic independent and supplementary prescribing. It is adapted from the Department of Health guidance 2006<sup>1</sup> to reflect current best practice by other professions in implementing prescribing<sup>2</sup>

### *Scope of this guidance and impact of devolution*

1. This guide sets out the steps to implement independent prescribing in the UK. Medicines legislation permits the introduction of independent prescribing for paramedics across the UK, but it is for the devolved administrations in Scotland, Wales and Northern Ireland to decide whether and how it is implemented for the NHS in their countries.
2. This guide has been produced to help promote safe and effective prescribing by paramedic prescribers and is applicable to both the NHS and the independent and voluntary sectors.
3. NHS England is tasked with creating the NHS of the future that will work collaboratively across all sectors, with social care and commissioners and with patients and carers. The Government's mandate for NHS England<sup>3</sup> and the Next Steps<sup>4</sup> expect 7-day availability of services, movement of some services from secondary to primary care, reduction of patients attending A&E/being admitted to hospital when it is not the best place for their treatment, improvements in the care of patients with mental health problems and provision of seamless, 'joined up' care close to patients homes- which may be care homes. New care models are required to deliver many of these improvements which include an increase in the number of health professionals who can prescribe, supply or administer medicines to patients.
4. The guidance is applicable to paramedic prescribing in all settings; where there are setting-specific requirements or information this is indicated in the document. It is

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<sup>1</sup> Department of Health (2006) Improving Patients' Access to Medicines: A Guide to Implementing Nurse and Pharmacist Independent Prescribing within the NHS in England [Click Here](#)

<sup>2</sup> Whenever prescribing is referred to in this document, this refers to independent and supplementary prescribing

<sup>3</sup> Department of Health (2017) The Government's mandate to NHS England for 2017-18 [Click Here](#)

<sup>4</sup> NHS England (2017) Next steps on the NHS Five Year Forward View [Click Here](#)

expected that independent prescribing will take place in urgent and emergency care settings, such as GP practices and emergency departments. Where prescribing roles emerge, employers will need to strengthen governance arrangements as outlined in this document.

5. In the context of prescribing, paramedics must be working in advanced clinical practice roles to be eligible to train to become prescribers. In this document, where reference is made to paramedic prescribers this includes only advanced paramedics.
6. The content of this document is current at the time of publication. It is expected that employers, managers and individual paramedic prescribers check recent guidelines and legislation to ensure up to date practice.
7. Where a paramedic is employed by more than one organisation, the prescribing role and attendant governance must be derived from each employer individually, rather than used interchangeably from a single employer (unless a previously agreed and governed arrangement exists). It is hoped that organisations will come together to ensure that their governance arrangements are in alignment.

## **Paramedic Prescribing**

### *Definitions of independent and supplementary prescribing*

8. Independent prescribing is defined as prescribing by an appropriate practitioner<sup>5</sup> (doctor, dentist, paramedic, nurse, pharmacist, physiotherapist, podiatrist, optometrist, diagnostic and therapeutic radiographer) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing medicines.
9. In partnership with the patient, independent prescribing is one element of the clinical management of a patient. It requires an initial patient assessment, interpretation of that assessment, a decision on safe and appropriate therapy, and a process for ongoing monitoring. Normally prescribing would be carried out in the context of practice within a multidisciplinary healthcare team, either in a hospital, a community setting or other healthcare provider setting, and within a single, accessible healthcare record.
10. Supplementary prescribers (paramedics, nurses, pharmacists, physiotherapists, diagnostic and therapeutic radiographers, dietitians, podiatrists and optometrists) can

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<sup>5</sup> Within medicines legislation the term used is 'appropriate practitioner'

prescribe in partnership with a doctor (or dentist). Supplementary prescribers are able to prescribe any medicine, including controlled drugs and unlicensed medicines that are listed in an agreed clinical management plan. All supplementary prescribers may prescribe for any medical condition, provided that they do so under the terms of a patient-specific clinical management plan (CMP) agreed with a doctor. The CMP will be drawn up, with the patient's agreement, following diagnosis of the patient. Supplementary prescribing may still be the most appropriate mechanism for prescribing, for instance where an independent prescriber is newly annotated as a prescriber or where a team approach to prescribing is clearly appropriate, or where a patient's CMP includes certain medicines which the prescriber cannot prescribe independently (for example some controlled drugs).

11. Non-medical health professionals who are legally able to train to become independent prescribers will also be assessed as supplementary prescribers and their professional registration will be annotated as such<sup>6</sup>.

#### *Legal basis of independent prescribing by advanced paramedics*

12. The initial legal basis for the introduction of nurse prescribing was provided by the following regulations:
  - The Medicinal Products: Prescription by Nurses, etc. Act 1992 [which amended the National Health Service Act 1977 (section 41) and the Medicines Act 1968 (section 58)];
  - The Medicinal Products: Prescription by Nurses, etc. Act 1992: (Commencement No 1) Order 1994.
13. Subsequently, section 63 of the Health and Social Care Act 2001 enabled the Government to extend prescribing responsibilities to other health professions, including pharmacists. It also enabled the introduction of new types of prescriber, including the concept of a supplementary prescriber.
14. The Medicines and Human Use (Prescribing) (Miscellaneous Amendments) Order of May 2006 and associated medicines regulations, and subsequently the Human Medicines Regulations 2012 and associated amendments enable specific non-medical health professions to undertake independent prescribing responsibilities.

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<sup>6</sup> Please refer to "Practice Guidance for Paramedic Supplementary and Independent Prescribers" available via the College of Paramedics web site [Click Here](#)  
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### *Aims of independent prescribing*

15. It is government policy to extend prescribing responsibilities to non-medical professions to: -

- improve patient care without compromising patient safety;
- make it easier for patients to get the medicines they need;
- increase patient choice in accessing medicines;
- make better use of the skills of health professionals;
- contribute to the introduction of more flexible team working across the NHS.
- enable patients to be seen and treated in the most appropriate setting by an appropriately skilled health professional.
- Support medicines optimisation
- Increase capacity to respond to changing demand on services

16. Organisations should develop their strategic plan for the use of non-medical prescribing to include prescribing by advanced paramedics. Typically, this would involve senior managers and clinicians (doctors, paramedics, pharmacists) and the drugs and therapeutics committee (or equivalent medicines governance and optimisation committee). The plan should be approved at Board level and would, for example:

- recognise the benefits to patients of non-medical prescribing;
- identify an initial range of clinical areas where patients could benefit;
- identify a way to support and sustain the transition of staff to prescribing roles and the services they currently provide;
- develop a communications plan aimed at informing both patients and all clinical and managerial staff;
- include timescales for implementation;
- identify a lead director to be responsible for implementation.

### *NHS care settings in which paramedic prescribing could apply*

17. Increasingly, paramedics are working in a wider range of multidisciplinary settings, including; GP practices and primary care, community services, secondary care including critical care units, out of hours, urgent and emergency care services and within integrated workforce models. Paramedics are employed by or contracted to

emergency and urgent care departments, primary care settings such as GP practices and other services.

18. Paramedic prescribers must adhere to the clinical governance arrangements put in place by the organisation for all non-medical prescribers as described in this document.
19. Prescribing in primary care settings such as GP practices, community clinics and patients' homes usually makes use of FP10 prescription forms. Therefore, this document includes guidance on handling FP10 forms securely (see Annex D).

## Implementation strategy

*Which paramedics can act as prescribers?*

20. Paramedics must be practising at an advanced level of practice, as defined by Health Education England in collaboration with NHS England and the allied healthcare professionals' professional bodies. Advanced practice is defined as:

*“Advanced clinical practitioners (ACPs) come from a range of professional backgrounds such as nursing, pharmacy, paramedics and occupational therapy. They are healthcare professionals educated to master’s level in Advanced Clinical Practice and have developed the skills and knowledge to allow them to take on expanded roles and scope of practice caring for patients.”<sup>7</sup>*

Advanced Clinical Practice is delivered by experienced registered healthcare practitioners. It is a level of practice characterised by a high level of autonomy and complex decision-making. This is underpinned by a master’s level award or equivalent that encompasses the four pillars of clinical practice, management and leadership, education and research, with demonstration of core and area specific clinical competence.

Advanced Clinical Practice embodies the ability to manage complete clinical care in partnership with patients/carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance patient experience and improve outcomes.<sup>8</sup>

21. A paramedic prescriber must have their name held on the Health and Care Professions Council (HCPC) professional register, with an annotation signifying that

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<sup>7</sup> Health Education England (2016) Advanced Clinical Practice [Click Here](#)

<sup>8</sup> Health Education England (2017) Definition of Advanced Clinical Practice [Click Here](#)

the paramedic has successfully completed an approved programme of preparation and training for paramedic independent and supplementary prescribing.

*Selection of advanced paramedics to train to become prescribers.*

22. The selection of paramedics who will be trained as prescribers is a matter for employing organisations who are best placed to assess local service and patient needs. Potential prescribers and organisations/managers wishing to implement paramedic prescribing should complete the checklist in **annex F**.

23. The entry requirements for HCPC registrants are listed in the following table (Outline Curriculum Framework 2017<sup>9</sup>):

a) Be registered with the HCPC in one of the relevant Allied Health Professions. AND
b) Be professionally practising in an environment where there is an identified need for the individual to regularly use independent prescribing (paramedics) AND
c) Be able to demonstrate support from their employer/sponsor* including confirmation that the entrant will have appropriate supervised practice in the clinical area in which they are expected to prescribe. AND
d) Be able to demonstrate medicines and clinical governance arrangements are in place to support safe and effective supplementary and/or independent prescribing AND
e) Have an approved medical practitioner, normally recognised by the employer/commissioning organisation as having: I) experience in the relevant field of practice, II) training and experience in the supervision, support and assessment of trainees and III) has agreed to; - Provide the student with opportunities to develop competences in prescribing - Supervise, support and assess the student during their clinical placement. AND
f) Have normally at least 3 years relevant post-qualification experience in the clinical area in which they will be prescribing. AND
g) Be working at an advanced practitioner or equivalent level. AND

<sup>9</sup> Allied Health Professions Federation (2017) Outline Curriculum Framework for Prescribers [Click Here](#)  
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h) Be able to demonstrate how they reflect on their own performance and take responsibility for their own Continuing Professional Development (CPD) including development of networks for support, reflection and learning.

AND

i) In England and Wales, provide evidence of a Disclosure and Barring Service (DBS) or AccessNI check within the last three years or, in Scotland, be a current member of the Protection of Vulnerable Groups (PVG) scheme.

\*If self-employed, must be able to demonstrate an identified need for prescribing and that all appropriate governance arrangements are in place

24. The three key principles that should be used to prioritise potential applicants are:

- to maximise patient safety;
- To provide maximum benefit to patients and the NHS in terms of quicker and more efficient access to medicines for patients and to support medicines optimisation/streamlining clinical pathways;
- to make better use of the professional's skills to support service transformation.

The individual practitioners must also understand and accept the higher level of clinical responsibility and accountability associated with prescribing.

25. NHS organisations may find it helpful to work together locally to agree priorities for access to prescribing courses in alignment with local priorities and in collaboration with Local Workforce Advisory Boards and Sustainability and Transformation Partnerships.

### *Commissioning services*

26. Advanced Paramedic prescribing will give providers of care and all who commission services the opportunity to transform service delivery. A wider range of professionals who can act as prescribers provides a range of skills and expertise from which to draw to meet patient needs. Using paramedic prescribers can, amongst other things, help to:

- fill geographical or skills gaps in services;
- promote care closer to home
- minimise delays to treatment
- meet the needs of patient groups who find it difficult to access services, e.g. housebound people;
- reduce avoidable admissions

### *Funding for paramedic prescribing training courses*

27. In some regions, funding for education programmes is now devolved to NHS organisations, in others the funding is managed by Health Education England. It is for NHS organisations to agree how this funding is best used to meet the needs of their client group.

### *Non-NHS staff*

28. Advanced Paramedics employed by non-NHS organisations, and who provide the majority of their clinical services to NHS patients (e.g. out-of-hours provider) may have their training funded. This may need to be considered with commissioners.

### *Conflicts of interest*

29. In nominating for training any paramedics whose posts are directly or indirectly funded by pharmaceutical and other companies, employers should be aware of, and take necessary steps to resolve, any conflicts of interests that may subsequently arise in the paramedic's practice.

30. Practice guidance 42 in the *Practice Guidance for Paramedic Supplementary and Independent Prescribers* document written by the College of Paramedics states the requirements of the paramedic prescriber where there are conflicts of interest.

31. HCPC registrants should make patients aware of that interest and must ensure independence from influence when prescribing and maintain a register of interests which may be produced on request. The register may be kept by the individual or completed through organisational corporate governance mechanisms.

32. NHS bodies should bear in mind issues of potential conflict of interest when they are considering commercial sponsorship of events aimed at prescribers.

### *Funding from other sources*

33. If it so wishes, an NHS organisation or a private organisation may also pay for the training of paramedics through other sources of funding. Individual paramedics may choose to fund themselves; this is an arrangement with the university of their choice but they must still meet all the entry requirements for the course (refer to **Annex F**). Caution should be taken to avoid creating a conflict of interest in relation to sources of funding.

## Training and preparation for independent prescribing

### *Training programmes for independent prescribing*

34. The Health and Care Professions Council (HCPC) has set out standards in respect of prescribing training for paramedics, and will only validate new recordable courses against these (see HCPC website). The *Outline Curriculum Framework (OCF)*, hosted by the Allied Health Professions Federation defines the entry criteria and specific curriculum for all allied health professionals legally able to prescribe. Only successful completion of programmes approved by the HCPC will lead to annotation on the HCPC register as a paramedic prescriber. The programme must have been approved for paramedics before a member of that profession may enter the programme. It is important to note that not all programmes offer access to all the prescribing professions. The HCPC offers information about the programmes they have approved on their website; with contact details for the relevant university for more specific information.
35. Health Education England has some level of influence over the detail of the curriculum for prescribing training (as commissioner of the course). It is expected that course commissioners and validators approve only those courses that demonstrate content that is consistent with published guidance and that the learning outcomes of the curricula are to be achieved.
36. Approved education programmes leading to annotation on the relevant professional register as an independent and supplementary prescriber must be a specific programme of preparation at a minimum of degree level (level six), usually Master's (level 7). The programme comprises a minimum of 26 days at a Higher Education Institution (HEI) plus 12 days 'learning in practice', during which a supervising designated medical practitioner will provide the student with supervision, support and opportunities to develop competence in prescribing practice. The programme of training and preparation may be spread over a period of time defined in the Outline Curriculum Framework (AHPF, 2018). The student will also need to undertake an element of self-directed learning. For distance learning programmes, there must be a minimum of 8 face-to-face taught days (excluding assessment) plus 10 ten days protected learning time. In exceptional circumstances where this is not practically possible, video-conferencing in which interaction between all participants is possible will be acceptable. Attendees on the multidisciplinary training programmes will be

already expert practitioners working at advanced clinical practice level and meeting the entry requirements as detailed in paragraph 23.

37. The training programmes include an assessment of theory and practice that must be passed before the practitioner's entry on the HCPC register is annotated, to indicate that he/she has successfully completed a prescribing training programme.
38. Individual higher education institutions, where appropriate, may use approved prior learning (APL) or exemptions, to give credit for previous learning.
39. In addition to the time spent on the formal programme, it is important that employers of paramedics undertaking the programme should recognise the demands of private study and provide support where necessary. Employers may also consider providing mentoring opportunities for these paramedics (see below).

#### *Supervising/Designated Medical Practitioner (DMP)*

40. The period of learning in practice will be directed by a DMP, who will also be responsible for assessing whether the learning outcomes have been met and whether the trainee has acquired certain competencies, as identified in the *Competency framework for all prescribers*<sup>10</sup>.
41. The Designated Medical Practitioner (DMP) has a critical and highly responsible role in educating and assessing the non-medical prescriber and assuring competence in prescribing.
42. Before taking on the role of DMP, the doctor and the HEI should consider the implications of undertaking this role safely and effectively. It is then important that the DMP and the HEI running the prescribing programme should work closely together.
43. '*Training non-medical prescribers in practice – A guide to help doctors prepare for and carry out the role of designated medical practitioner*' published by the National Prescribing Centre in 2005 should help to inform the selection of Designated Medical Practitioners and supports DMPs in undertaking this role.
44. Training new prescribers will undoubtedly take up some time. The approach to teaching and learning should be developed on an individual basis, so it is difficult to predict how much time this will involve.

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<sup>10</sup> Royal Pharmaceutical Society (2016) A Competency Framework for all Prescribers [Click Here](#)  
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### *'Buddying' schemes during training*

45. It is unlikely that a trainee will need to spend all of the period of learning in practice with their designated medical practitioner (DMP), as other clinicians may be better placed to provide some of the learning opportunities. However, the DMP remains responsible for assessing whether all of the learning outcomes have been met. Some form of 'buddying' link may also be valuable, for instance, with a current paramedic, nurse or pharmacist prescriber, or with a senior and experienced pharmacist.

## **Continuing Professional Development**

46. All paramedics have a professional responsibility to keep themselves abreast of clinical and professional developments. This is no less true for prescribing. Paramedic prescribers will be expected to keep up to date with evidence and best practice in the management of the conditions for which they prescribe, and in the use of the relevant medicines. The HCPC standards of continuing professional development expect that all registrants undertake CPD related to their practice; prescribers must include their prescribing practice in this activity.<sup>11</sup>

47. Paramedics may use the learning from this activity as part of their CPD activity. The employer should ensure that the practitioner has access to relevant education and training provision. It is good practice for employers to support paramedic prescribers in pursuing self-directed study. Details of additional training and updating will need to be incorporated by the paramedic into their personal professional profile in order to meet re-registration requirements set by the HCPC.

48. In addition, the document "*a competency framework for all prescribers*" published by the Royal Pharmaceutical Society<sup>12</sup> will help paramedic prescribers to structure CPD activities by comparing their knowledge and competence against a set of competencies expected of an exemplar prescriber.

### *'Buddying'/mentor post - qualification*

49. Support from other professional colleagues is invaluable to non-medical prescribers, especially to those who are newly qualified. Many non-medical prescribers already have a buddy/mentor after qualifying to prescribe. This could be a doctor, paramedic

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<sup>11</sup> Health and Care Professions Council (2012) Your guide to our standards for continuing professional development [Click Here](#)

<sup>12</sup> Royal Pharmaceutical Society (2016) A Competency Framework for all Prescribers [Click Here](#)

or pharmacist and is a sensible way of enhancing continuing professional development.

50. Supplementary prescribing is also a useful mechanism to enable new non-medical prescribers to develop their expertise and confidence in prescribing.

### **Prescribing medicines under independent prescribing arrangements**

51. Paramedics who have successfully completed an independent prescribing course may prescribe any licensed medicine, (i.e. products with a valid marketing authorisation (licence) in the UK), and any licensed medicine used outside of the marketing authorisation (off-licence / off-label), for any medical condition within their clinical competence, scope of practice and level of experience. Subject to legislative change, they may be permitted to prescribe certain controlled drugs to be administered via specified routes. This list is available in the Drug Tariff and the BNF.

#### *Prescribing within competence*

52. All paramedic prescribers must work within their own level of professional competence and expertise, and must seek advice and make appropriate referrals to other professionals with different expertise. Paramedics are accountable for their own actions, and must be aware of the limits of their skills, knowledge and competence. Paramedic prescribers must act within the HCPC standards of professional conduct, performance and ethics<sup>13</sup>, and the HCPC standards for prescribing<sup>14</sup>.

#### *Controlled Drugs*

53. Subject to changes to the Misuse of Drugs Act, paramedic independent prescribers will be able to prescribe from the list of controlled drugs specified in **annex E**.

#### *Prescribing licensed medicines for unlicensed uses ('off-label' or 'off-licence')*

54. Paramedic prescribers may prescribe medicines independently for uses outside their licensed indications / UK marketing authorisation (known as 'off-licence' or 'off-label'). They must however, accept professional, clinical and legal responsibility for that prescribing, and should only prescribe 'off-label' where it is accepted clinical practice. A local policy for the use of medicines 'off-label' should be approved through mechanisms such as drug and therapeutic committees or the equivalent. The

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<sup>13</sup> Health and Care Professions Council (2016) Standards of conduct, performance and ethics [Click Here](#)

<sup>14</sup> Health and Care Professions Council (2013) Standards for Prescribing [Click Here](#)

prescriber should explain the situation to the patient/guardian where possible, but where a patient is unable to agree to such treatment, the prescriber should act in accordance with best practice in the given situation and within the policy of the employing organisation.

#### *Unlicensed medicines (products without a UK marketing authorisation)*

55. Paramedic independent prescribers are not permitted to prescribe unlicensed medicines. If the paramedic prescriber uses supplementary prescribing and there is a clinical management plan (CMP) in place which includes the unlicensed medicine, then unlicensed medicines can be prescribed. The CMP is agreed between a doctor and non-medical prescriber with agreement of the patient.

#### *Borderline Substances*

56. All NHS prescribers will need to abide by any NHS terms of service under which they operate. For example, borderline substances may be prescribed but the prescription will need to be marked 'ACBS'. A list of Advisory Committee of Borderline Substances (ACBS) approved products and the circumstances under which they can be prescribed, can be found in part XV of the Drug Tariff. Although this is a non-mandatory list, paramedic independent prescribers should restrict their prescribing of borderline substances to items on the ACBS approved list. They should also work within the guidance of their employing organisation.

#### *Appliances / Dressings in Part IX of the Drug Tariff*

57. Paramedic independent prescribers may also prescribe any appliances or dressings that are listed in Part IX of the Drug Tariff. Paramedics prescribing in secondary care are not restricted to prescribing appliances/dressings from part IX of the Drug Tariff, but should take into account local formulary policies and the implications for primary care.

### **Clinical governance in prescribing**

58. Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

59. Chief executives are legally accountable for the quality of care that patients receive and for securing patient safety.

60. The employing organisation must ensure that paramedic prescribing is included within their overall clinical governance framework, to ensure that paramedics practice safely and competently. An example clinical governance framework for paramedic independent prescribing can be found in annex D. It must include systems for:

- selection – all entrants to prescribing training must be selected according to criteria indicating their potential to prescribe safely in the area in which they will practice. This will usually include evidence that they have appropriate specialist knowledge and that they are required to be able to prescribe within their role/new role/new way of working.
- completion of accredited education programmes – the HCPC provides and assesses the standards for training and education programmes. Employers also have a duty to ensure that those training to prescribe are supported through their training programme
- ensuring that the names of prescribers are annotated on their professional register, before they begin to prescribe. This should be ascertained via the usual register checking arrangements that are undertaken for new employees
- ensuring arrangements are in place for assessment of practice, clinical supervision, audit, and continuing professional development for all paramedic prescribers
- developing a risk management plan – this will ensure that potential risks associated with extending clinical practice are recognised and minimised
- ensuring that the parameters of an individual's prescribing are agreed between the prescriber, their manager or local professional lead (e.g. the non-medical prescribing lead), and their employer. This is best carried out using a personal formulary approach which is a continuation from that developed during the course of study. The formulary should include the context in which the non-medical prescriber will prescribe the medicine and how the knowledge and competence to prescribe the medicine was achieved and is being maintained / developed.
- ensuring that drug and therapeutic committees (or equivalent) are aware of the medicines being prescribed by paramedic prescribers

61. Paramedics should use clinical supervision arrangements or equivalent as an opportunity for reflection on prescribing, as well as other aspects of practice. The model of clinical supervision should be agreed at local level, taking account of other staff support mechanisms and resources.
62. Peer review, support and mentoring arrangements should be established for paramedics. Audits, clinical governance arrangements and their CPD requirements will allow paramedics to reflect on their prescribing practice.
63. A review of prescribing by paramedics should be carried out as part of the overall prescribing monitoring arrangements and as a suitable area of practice for regular audit. This should include prescription and cost data (ePACT) available from the Business Services Authority (if using FP10 prescriptions) and from hospital internal systems.

#### *Independent/Private sector*

64. Paramedic prescribers who work outside NHS settings where clinical governance systems may be different or may not be applied in the same way, must ensure they comply with professional body requirements to demonstrate their competence to practice. For example, they must be able to show how they audit their practice, keep up-to-date with current guidance, and how they safeguard the patients in their care. Prescribing has the same requirements for education, training, supervision and audit, and is subject to the same standards of overarching clinical governance and safeguards for patient safety irrespective of setting<sup>15</sup>.

## **Good practice, ethics and issues for all prescribers**

### *Responsibility for prescribing decisions*

65. A paramedic prescriber can only order a medicine for a patient whom they have assessed for care. In primary care, a paramedic should only write prescriptions on a prescription pad bearing their own unique HCPC registration number. Accountability for the prescription rests with the non-medical prescriber who has prescribed or ordered the medicines.

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<sup>15</sup> College of Paramedics (2018) Practice Guidance for Paramedic Supplementary and Independent Prescribers [Click Here](#)

### *Informing patients*

66. Paramedic prescribers must ensure that patients are aware that they are being treated by a non-medical practitioner and of the scope and limits of their prescribing. So there may be circumstances where the patient has to be referred on to another healthcare professional, to access other aspects of their care.

### *Prescribing for self, family and friends*

67. Paramedic prescribers must not prescribe any medicine for themselves. Neither should they prescribe a medicine for anyone with whom they have a close personal or emotional relationship, other than in an exceptional circumstance<sup>16)</sup>

### *Gifts and benefits*

68. The advertising and promotion of medicines is strictly regulated under the Medicines (Advertising) Regulations 1994, and it is important that paramedic prescribers, and indeed all health professionals, make their choice of medicinal product for their patients on the basis of evidence, clinical suitability and cost effectiveness alone.
69. As part of the promotion of a medicine or medicines, suppliers may provide related inexpensive gifts and benefits for example pens, diaries or mouse mats. Personal gifts that are given to influence your prescribing activity are prohibited and it specified in law that a prescriber must not solicit or accept a gift, pecuniary advantage, benefit or hospitality that is prohibited by regulation<sup>17</sup>.
70. Companies may also offer hospitality at a professional or scientific meeting or at meetings held to promote medicines, but such hospitality should be reasonable in level and subordinate to the main purpose of the meeting. Employers should have local policies for working with the pharmaceutical industry which cover gifts and benefits, as well as, for example, access to prescribers and sponsorship. Prescribers should familiarise themselves with these policies and are expected to abide by them.
71. The Medicines and Healthcare products Regulatory Agency (MHRA) is responsible for enforcing the legislation on advertising and promotion of medicines. Any complaints about promotional practices should be referred to the MHRA or to the industry's self-regulatory body, the Prescription Medicines Code of Practice Authority.

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<sup>16</sup> College of Paramedics (2018) Practice Guidance for Paramedic Supplementary and Independent Prescribers [Click Here](#)

<sup>17</sup> UK Government (2012) Human Medicines Regulations [Click Here](#)  
**A Guide to Implementing Paramedic Prescribing within the NHS in the UK.**  
COP-IP003 – Feb18 v1.00

### *Guidance on Controlled Drugs*

72. The Home Office's Misuse of Drugs Act and associated regulations govern the prescribing of Controlled Drugs. For guidelines on the prescription of Controlled Drugs, healthcare professionals should refer to:

- Guidance from their respective professional bodies;
- NICE guideline [NG46] Controlled drugs: safe use and management 2016).<sup>18</sup>  
This guideline contains information on the post-Shipman changes to the legal framework around the use and management of controlled drugs. It signposts the user to the relevant legislation and guidance from Government, professional bodies and other agencies.
- The legal requirements for prescriptions for Schedule 2 and 3 Controlled Drugs are summarised in the British National Formulary
- See also part XVIIIB of the Drug Tariff

### **Patient records: Access and updating**

73. All health professionals are required to keep accurate, legible, unambiguous and contemporaneous records of a patient's care. There is no single model or template for a patient record (although for guidance, staff should refer to the standards published by the relevant professional/regulatory body), but a good record is one that provides in a timely manner all professionals involved in a patient's treatment with the information needed for them to care safely and effectively for that patient. It is a necessary way of promoting communication within the healthcare team and between practitioners and their patients/clients. Good record keeping is, therefore, both the product of effective team working and a pre-requisite for promoting safe and effective care for patients.

74. Best practice suggests that the details of any prescription, together with other details of the consultation with the patient, should be entered onto the shared patient record immediately, or failing that, as soon as possible after the consultation. **Only in exceptional circumstances (e.g. the intervention of a weekend or public holiday) should this period exceed 24 hours from the time of writing the prescription.** This information should also be entered at the same time onto the

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<sup>18</sup> National Institute for Health and Care Excellence (2016) Controlled drugs: safe use and management [Click Here](#)

patient record and onto the paramedic patient record (where a separate record exists).

75. It is recommended that the record indicates clearly:

- The date of the prescription;
- The name of the prescriber (and that they are acting as a paramedic independent prescriber or paramedic supplementary prescriber);
- The name of the item prescribed, together with the quantity (or dose, frequency and treatment duration).

76. To aid safe administration of medicines, the record should include:

- The name of the item prescribed, the strength (if any) of the preparation, the dosing schedule and route of administration, e.g. 'paracetamol oral suspension 120mg/5mls to be taken every four hours by mouth as required for pain, maximum of 20mls in any 24 hours'.

77. In the case of topical medicines the name of the prescribed item, the strength (if any), the quantity to be applied and the frequency of the application should be indicated. For dressings and appliances, details of how they are to be applied and how frequently changed, are useful. It is recommended that any advice given on General Sales List and Pharmacy medicines provided 'over the counter' is also recorded.

## **Adverse Drug Reaction Reporting**

### *MHRA Yellow Card Scheme*

78. The Yellow Card Scheme is a voluntary scheme, through which healthcare professionals notify the Medicines and Healthcare products Regulatory Agency (MHRA) of suspected adverse drug reactions. The MHRA encourages the reporting of:

- all suspected adverse drug reactions to newly licensed medicines that are under intensive monitoring/surveillance (identified by a ▼ symbol both on the product information for the drug and in the BNF and MIMS), and
- all serious suspected adverse drug reactions to all other established medicines, including herbal medicines. Serious reactions include those that are fatal, life threatening, disabling, incapacitating or which result in or prolong hospitalisation and/or are medically significant.

79. The electronic Yellow Card provides a simple and fast way to report suspected adverse reactions. The electronic Yellow Card, together with instructions on how to use it, is available at [www.yellowcard.mhra.gov.uk](http://www.yellowcard.mhra.gov.uk) Health professionals are encouraged to report all suspected adverse drug reactions using this method, although hard copy Yellow Cards are also acceptable (and can be found bound to the back of the British National Formulary). Patients, parents, carers etc. can also report suspected adverse drug reactions using the above methods and there is also a Freephone number - 0808 100 3352, that can be used.
80. The bulletin “Drug Safety Update”, issued by the MHRA contains advice and information on drug safety issues. All prescribers are encouraged to routinely consult the bulletin and keep up-to-date with new information about safe use of medicines. Copies are also available from the MHRA; prescribers can register to receive the bulletin by email<sup>19</sup>.

#### *Role of the National Reporting and Learning System*

81. If a patient suffers harm due to an adverse incident involving medicines, or if harm could have been caused to the patient by the medicine (a near miss), the incident or near miss should be reported by the paramedic prescriber using both local and national reporting systems. The National Reporting and Learning System (NRLS), (which includes the National Patient Safety Agency (NPSA), and is now part of NHS England) aims to improve the safety of NHS patient care, by promoting a culture of reporting and learning from adverse incidents across the NHS<sup>20</sup>. A reporting system, the NRLS has been developed to draw together information on adverse incidents. This will help the NHS to understand the underlying causes of patient safety problems, and to act to introduce practical changes to prevent mistakes.
82. All NHS organisations in England and Wales can now submit reports of patient safety incidents to the NRLS. These reports will enable NHS Improvement to build a clearer national picture of the problems affecting patient safety.
83. The NRLS allows NHS staff and independent contractors to report the incidents that they are involved in or witness, confidentially and anonymously. Two routes are available to enable them to report:

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<sup>19</sup> UK Government (2018) Drug Safety Update [Click Here](#)

<sup>20</sup> NHS Improvement (2018) National Reporting and Learning System (NRLS) [Click Here](#)

- A direct reporting route to the NRLS
- Reporting through the local healthcare organisation's established system.

84. NHS Improvement publishes statistics on trends and issues identified through the NRLS to promote a learning culture in the NHS. NHS Improvement will also use the data to deliver effective, practical and timely solutions to the NHS, to help staff and organisations improve the safety of the patients they care for.

## **Legal and Clinical Liability**

### *Liability of prescriber/professional indemnity*

85. Prescribers are accountable for all aspects of their prescribing decisions. They should therefore only prescribe those medicines they believe to best of their knowledge are safe and effective for the patient and the condition being treated. They must be able to recognise and deal with pressures (e.g. from the pharmaceutical industry, patients or colleagues) that might result in inappropriate prescribing.
86. All prescribers should ensure that they have sufficient professional indemnity insurance, for instance by means of membership of a professional organisation or trade union which provides this cover.
87. The UK Government has introduced legislation<sup>21</sup> which requires HCPC registrants to have a professional indemnity arrangement in place as a condition of their registration with HCPC. Prescribers must also be aware of the level of indemnity to determine whether it is appropriate cover for practising as such.
88. Both the employer and employee (or contractor) should ensure that the employee's job description (or contractor's agreed arrangements) includes a clear statement that prescribing is required as part of the duties of that post or service.

### *Liability of employer*

89. Where a paramedic is appropriately trained and annotated on the HCPC register and prescribes as part of their professional duties with the consent of their employer, the employer is held vicariously liable for their actions. In addition, paramedic prescribers are individually professionally accountable to the HCPC for this aspect of

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<sup>21</sup> UK Government (2014) The Health Care and Associated Professions (Indemnity Arrangements) Order 2014 [Click Here](#)

their practice, as for any other, and must act at all times in accordance with the HCPC Standards of Conduct, Performance and Ethics<sup>22</sup>

## Dispensing of prescribed items

### *Dispensing Doctors in primary care*

90. Where a GP practice is a dispensing practice, prescriptions from independent prescribers can be dispensed by the practice but only for the patients of that practice. Dispensing doctors cannot dispense prescriptions written by paramedic prescribers for patients of other practices.
91. Reimbursement for prescriptions written by paramedic prescribers can be claimed by dispensing doctors; payment for the prescriptions submitted will be made to the senior partner.

### *Simultaneous prescribing and dispensing or prescribing and administration of a medicine*

92. There should, other than in exceptional circumstances, be separation of prescribing and dispensing roles, in keeping with the principles of safety, clinical and corporate governance. The “*Practice Guidance for Paramedic Independent and Supplementary Prescribers*”<sup>23</sup>, published by the College of Paramedics states that paramedics should ensure that there is separation of prescribing and dispensing wherever possible. In exceptional circumstances, where a paramedic is both prescribing and dispensing a patient’s medication, a second suitably competent person should be involved in the checking process.
93. In such exceptional circumstances, prescribing and dispensing can be carried out by the same individual, provided that:
- clear accountability arrangements are in place to ensure patient safety and probity, and;
  - there are audit and clinical governance arrangements in place, which can track prescribing and dispensing by paramedic prescribers.

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<sup>22</sup> Health and Care Professions Council (2016) Standards of conduct, performance and ethics [Click Here](#)

<sup>23</sup> College of Paramedic (2018) College Web Site [Click Here](#)

94. A similar scenario would be simultaneous prescribing and administration. The following is taken from the College of Paramedics "*Practice Guidance for Paramedic Supplementary and Independent Prescribers*<sup>24</sup>".

"Simultaneous prescribing and administration should be undertaken only in exceptional and rare circumstances and only if it is in the patient's best interests. You should ensure wherever possible that a second person checks that your prescription is what is administered to the patient. The second "checker" need not be a prescriber or registered health-professional themselves but should be able to verify that the correct medicine is being administered to the patient."

## Verification of prescribing status

### *Role of the pharmacist on verification of prescribing status*

95. The dispensing pharmacist will need to be sure that the prescriber is annotated as a paramedic prescriber.

96. The prescription form will indicate whether a prescriber is a paramedic prescriber. The dispensing pharmacist will, of course, need to use their professional judgement, just as they do for any prescriptions, to assess whether a prescription is appropriate for a particular patient.

97. To enable pharmacists to check whether a prescription handed in for dispensing is bona fide, **all** NHS employers should keep a list of all paramedic prescribers employed by them. It is also recommended that the employing authority (NHS or private) holds a copy of the prescriber's signature. Individuals should be prepared to provide specimen signatures to pharmacists, should that be required.

98. Most enquiries from dispensing pharmacists will be resolved by telephoning the prescriber, or the prescriber's employer. However, for general queries about the paramedic's prescribing annotation (e.g. in the case of receiving a private prescription), the pharmacist can interrogate the professional register on the HCPC website <http://www.hcpc-uk.org>. Using the paramedic prescriber's profession, surname and/or registration number will confirm if the paramedic has the relevant annotation(s).

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<sup>24</sup> College of Paramedics (2018) Practice Guidance for Paramedic Supplementary and Independent Prescribers [Click Here](#)

99. In the case of FP10 prescriptions, the Prescription Pricing Division of the NHS Business Services Authority (NHSBSA) checks to ensure that the paramedic independent prescriber who has written the prescription is listed as having permission to prescribe against that cost code, such as the GP practice, service or organisation.

### **Dispensing by appliance contractors**

100. When a paramedic becomes aware that the patient intends to have a prescription dispensed by an appliance contractor, they must ensure that the prescription does not contain medicinal preparations. Appliance contractors cannot dispense medicinal preparations.

### **Urgent dispensing**

101. Occasionally a paramedic prescription may require dispensing out of normal pharmacy opening hours. Many community pharmacies are open out-of-hours, the NHS Choices website contains a full list of community pharmacies including opening hours. Hospitals and Out-of-Hours Services will have local arrangements for supplying medicines out-of-hours, which should be brought to the attention of all prescribers.

### **Dispensing of items in Scotland, Wales and Northern Ireland**

102. Prescriptions written by paramedic prescribers in England will only be dispensable by pharmacists in Scotland, Wales and Northern Ireland when the devolved administrations have amended their pharmaceutical regulations, to permit them to be dispensed at NHS expense.

### **Dispensing items against paramedic prescriber's prescriptions in hospital pharmacies**

103. An up-to-date list of all qualified paramedic prescribers employed by the hospital will need to be kept in the hospital pharmacy. Pharmacy staff should check the prescriber against the list. The same process will apply for in-patient, outpatient and discharge prescriptions. In general, prescriptions written on forms intended for dispensing in the community (FP10 forms) are not intended for dispensing by hospital pharmacies.

## Prescribing monitoring information

### *Prescribers contracted to a GP practice*

104. The NHS Business Services Authority (NHSBSA) reimburses costs to dispensing contractors and provides essential information electronically to authorised users. Prescribing by paramedic prescribers on FP10 prescriptions will be identifiable in ePACT.net services and other NHSBSA Information Systems. NHS England Local Area Teams will be expected to provide routine data analysis of all prescribing which may include analysis of cost effectiveness and quality.
105. If a prescriber is prescribing on behalf of a GP practice, they can obtain prescribing data through electronic Prescribing and Financial Information for Practices (ePFIP) on the NHS Business Services Authority website: [www.nhsbsa.nhs.uk](http://www.nhsbsa.nhs.uk). This provides detail for individual prescribers, down to presentation and prescription quantity level. The NHS Business Services Authority website provides information about ePFIP and how to access it.

### *Prescribers contracted to a hospital trust*

106. Typically, the hospital pharmacy department will monitor prescribing and provide feedback on all prescribing in hospitals to both clinicians and managers. Many hospitals use electronic prescribing and administration systems which can generate prescribing data. Paramedic prescribers working in these settings should ask the non-medical prescribing lead for this information.
107. The route for accessing prescribing data for non-medical prescribers depends on where their prescribing costs are allocated. Paramedic prescribers can expect to receive information via their non-medical prescribing lead to monitor their prescribing.

## Annexes

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### **Annex A: Notification of prescriber details to the Prescription Pricing Division of the NHS Business Services Authority**

1. The details of paramedic prescribers employed and practising in a primary care setting and intending to prescribe on personalised FP10 prescriptions must be registered with the NHS Business Services Authority (NHSBSA) before prescriptions for that prescriber can be ordered. Hospital-based prescribers should refer to Annex E. This must not be done until the paramedic prescriber has passed all aspects of the prescribing course and has the qualification annotated on their professional register entry.
2. Notification of required details by the prescribers' employer or another authorised person to the NHSBSA enables the setting up of automatic monitoring processes, as well as allowing the provision of prescriber details to the supplier for the printing of prescription pads.
3. The current form as displayed on the NHSBSA website [www.nhsbsa.nhs.uk](http://www.nhsbsa.nhs.uk) must be used for notification. Additional forms from the website must be used to notify the NHSBSA of changes in circumstances (e.g. name) as they occur. The forms contain instructions for completion and the email address to which the completed form must be sent.

#### **Changes to prescriber details**

4. It is the responsibility of employers of paramedic prescribers who are registered with the NHSBSA and who are working in primary care settings, to ensure that changes to the prescriber's details are notified to NHSBSA as soon as they occur, e.g. change of name on marriage, change of telephone number. Failure to do this will mean that prescription forms will continue to be produced with the former (incorrect) details on them.

#### *Prescriber ceases employment / prescribing.*

5. The employer, must inform the NHSBSA as soon as possible when a prescriber is no longer carrying out prescribing duties (for example, because he/she has changed employer, been suspended from the relevant register or had his/her approval as a prescriber withdrawn for some reason). They must do this by submitting the relevant NHSBSA form as described above. This includes circumstances where the employer is contracted to provide services for other commissioning organisations.
6. Employers must annotate their lists of paramedic prescribers with the reasons for any changes, to ensure that an up-to-date record exists.

## Annex B – Prescription Forms- completion

1. All prescription forms require information to be entered on them (by printing or writing or a combination of both). In addition to the correct dispensing of the items prescribed, this allows for prescribing information and costs to be attributed to the correct prescriber and / or organisation, as well as to the correct prescribing budget.

### Prescribing in primary care settings

#### *Ordering prescription forms*

2. Employers should note that prescription forms are not issued automatically; authorised persons must order FP10 prescriptions from the supplier. Prescriptions should also be re-ordered as and when required.
3. Orders for a new prescriber's prescription forms should not be placed earlier than 42 days prior to the date the individual is scheduled to begin prescribing for the organisation, as the supplier cannot access NHSBSA data before this point.
4. Allow at least 4 working days between notifying changes to the NHSBSA and ordering prescriptions. This will allow time for data input and transmission of updated data files to the supplier. Orders are currently placed online and require the prescriber's correct details to have been uploaded from the NHSBSA prior to ordering.
5. Prescriptions are normally sent to the address of the person who orders them (an alternative address can be specified for invoicing purposes). Checks are made to ensure that FP10 prescriptions are only supplied to bona-fide NHS organisations. Difficulties with prescription orders should be addressed to the current supplier.

#### *Prescription forms FP10P pre-printing specification.*

6. The top of the prescribing area will be overprinted to identify the type of prescriber i.e. PARAMEDIC PRESCRIBER
7. The address box will be overprinted to identify:
  - the paramedic prescriber's name and registration number
  - the name, address and phone number of the employing organisation
  - the name and code of the organisation they are prescribing on behalf of
  - the practice code
8. Information about prescription overprinting and single sheet versions of the FP10 is available on the NHSBSA website<sup>25</sup>.
9. Any prescriber who works for more than one employer or in more than one setting for example they prescribe on behalf of two CCGs **must** have separate prescription pads for each organisation / or use FP10SS prescriptions, printed with the correct organisation details in the prescriber details area of the prescription form.

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<sup>25</sup> NHS Business Services Authority (2018) NHSBSA Web Site [Click Here](#)

## Prescribing by hospital-based paramedic prescribers

10. Paramedic prescribers prescribing for hospital inpatients or outpatients may use the following methods to prescribe:
- Hospital in-patient prescription form or sheet - to be used for inpatients and discharge supplies only. A prescription charge is not levied for inpatients.
  - Internal hospital prescription form – to be used for outpatients but only in cases where the hospital pharmacy will dispense the prescription. A prescription charge may be payable, unless the patient is exempt from prescription charges. (please note: internal hospital forms cannot be accepted for dispensing by community pharmacies).
  - Electronic prescription and administration systems- many hospitals are implementing these systems across all services provided by the organisation where medicines are prescribed and administered. Local support and implementation teams will enable the paramedic prescriber to be registered with the system and enabled to prescribe.
  - FP10 prescription forms, where the medicine will be prescribed by a hospital prescriber and dispensed in a community pharmacy. These are mainly used in circumstances where the service is delivered away from the hospital site and therefore the pharmacy (please note: the prescriber's employer should establish a local policy on the use of prescription forms in these circumstances.). These prescriptions are printed with previously agreed service-specific prescribing account details, not individual prescriber details. Prescribing (EPACT) data is available from the NHSBSA but is displayed at service level only. There is currently no requirement to notify the NHSBSA of details of hospital-based paramedic prescribers, or changes to their details. If paramedic prescribers need to use these prescriptions, they must write their prescribing designation on each prescription as: PARAMEDIC PRESCRIBER and the prescriber's HCPC registration number.

## Non-NHS Employees

12. A non-NHS paramedic prescriber cannot issue an FP10 type prescription, i.e. one which will be dispensed in a NHS community pharmacy, unless the organisation they work for is commissioned to provide an NHS service and has an arrangement which allows the non-NHS organisation to use NHS community pharmacy dispensing services. The NHS commissioner should organise the supply of FP10 type prescription forms (and obtain the prescribing code(s) to be used) for the non-NHS organisation, if this is appropriate.

## How to complete a prescription form

13. Detailed, up to date advice on prescription writing is contained in the British National Formulary (BNF). Paramedic prescribers must refer to the current edition of the BNF.

14. Details required on the front of the prescription form (to be entered by writing clearly and legibly using an indelible pen - preferably black or, where possible, by printing using a computer prescribing system) are as follows:

- the patient's title, forename, surname and address (including postcode) and if available the patient's NHS number
- patient's age and date of birth (must be printed by computer prescribing systems; for hand written prescriptions - enter if known e.g. from patient's notes - BUT it is a legal requirement to write the patient's age on the prescription when prescribing Prescription Only Medicines for a child under twelve years of age)
- for prescribing in primary care settings the prescription should contain the name of the prescribed item, formulation, strength (if any) dosage and frequency, and quantity to be dispensed. If a medicine is to be taken as required, a minimum dose interval should be specified. The name should reflect the description in the BNF, should be written clearly and not abbreviated
- the quantity prescribed should be appropriate to the patient's treatment needs, bearing in mind the need to avoid waste. Some medicines are only available in patient packs (or multiples thereof)<sup>26 27</sup> and special containers<sup>28</sup> and the quantity contained should be prescribed, provided this is clinically and economically appropriate. This also ensures that an authorised patient information leaflet is supplied with the medicine
- the quantity should be specified for solid preparations as number of dose-units (number of tablets, capsules, lozenges, patches etc.), for liquid measures in millilitres (mL or ml) or litres, for topical preparations by mass (grams, g) or volume (millilitres, mL or ml). Terms such as "1 Pack" or "1 OP" should not be used
- alternatively, for preparations to be given at a fixed dose and interval, the duration(s) of treatment can be given in place of quantity to be dispensed
- the unnecessary use of decimal points should be avoided e.g. 3mg not 3.0mg. Quantities of 1 gram should be written as 1g, less than 1 gram should be written in milligrams e.g. 500mg not 0.5g. Likewise, quantities less than 1mg should be

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<sup>26</sup> A patient pack is a manufacturer's pack approved by the Licensing Authority which has a label and leaflet and contains an amount of medicine such that the pack is capable of being given whole to a patient to meet all or part of a treatment course. For some medicines, special packs containing smaller quantities will be available for starter/titration/trial purposes.

<sup>27</sup> In the BNF, pack size is indicated as in this example "Net price 60-tab pack=£2.25". Wherever no pack size is indicated, as in "Net price 20=9p, the quantity is shown for price comparison purposes only.

<sup>28</sup> A special container is a pack from which it is not practicable to dispense an exact quantity, or a pack with an integral means of application. This currently includes sterile preparations, effervescent or hygroscopic products, liquid preparations which are intended to be added to bath water, coal tar preparations, viscous preparations and all products packaged in casters, tubes, dropper bottles, aerosols, puffers, roll-on packs, sachets, sprays, shakers, squeeze packs.

written in micrograms e.g. 100 micrograms not 0.1mg. Use of the decimal point is acceptable to express a range e.g. 0.5-1g. 'Micrograms' and 'nanograms' should not be abbreviated. Similarly, 'units' should not be abbreviated. See the BNF for the accepted list of abbreviations

- any warnings that will not be printed automatically onto the label for the medicine by the dispensing pharmacist (see the BNF for the list of warnings) must be written onto the prescription
  - computer-issued prescriptions must contain the same patient-specific data as described above. The prescription must be printed in English without abbreviation, the dose in numbers, the frequency in words and the quantity in numbers in brackets e.g. 40mg four times daily (112) or by indicating length of treatment required. The name of the medicine must come from a dictionary within the computer's memory. The BNF gives advice if the medicine required is not listed in the dictionary
  - in hospitals, prescriptions for inpatients should contain the name of the prescribed item, formulation, strength (if any), dosage and frequency. Where a defined length of treatment is required, this should be stated
  - for outpatients and discharge prescriptions, the requirements are the same as those for primary care settings, whilst recognising local policies for example on the length of treatment provided for outpatients and patients who are being discharged
  - the names of medicines should be written clearly following BNF descriptions
- **Paramedics are recommended to prescribe generically, except where this would not be clinically appropriate or where there is no approved generic name** – see the BNF, the Drug Tariff and/or the marketing authorisation (summary of product characteristics) of the medicine. Names of medicines and generic titles should not be abbreviated. Exceptions to this rule are for the prescribing of some dressings and appliances, and of compound or modified release medicines which have no approved non-proprietary name
    - directions for use, which should be in English and not abbreviated
    - where there is more than one item on a form, a line should be inserted between each item for clarity
    - unused space in the prescription area of the form should be blocked out with, for example, a diagonal line (to prevent subsequent fraudulent addition of extra items)
    - prescriber's signature and date and type of prescriber if not already printed
    - on hospital prescriptions only: the paramedic prescriber's name printed or handwritten in the box provided- to ensure that the dispensing pharmacist is aware who to contact if they have a query.

## Annex C: Security and safe handling of FP10 prescription forms

The security of prescription forms is the responsibility of both the employing organisation and the prescriber. The most up to date detailed guidance for security of prescription forms can be found on the NHS Protect section of the NHSBSA website [www.nhsbsa.nhs.uk](http://www.nhsbsa.nhs.uk). The following information is an extract from 'Security of Prescription Forms 2015'.<sup>29</sup> The full document must be referred to when writing organisational policies.

### The prescriber's responsibilities

1. Be aware that blank prescription forms in the wrong hands are like a blank cheque with an extremely high street value.
2. Prescription form stock in possession of prescribers should always be stored securely when not in use.
3. Prescribers should keep a record of the serial numbers of prescription forms issued to them. The first and last serial numbers of pads should be recorded.
4. Prescribers should be encouraged to use prescription forms in number sequence order to aid tracking of usage, should a potential loss occur
5. To reduce the risk of misuse, blank prescriptions should never be pre-signed.
6. Patients, temporary staff and visitors should never be left alone with prescription forms or allowed into secure areas where forms are stored.
7. Prescribers on home visits should, before leaving the practice premises, record the serial numbers of any prescription forms/pads they are carrying. Only a small number of prescription forms should be taken on home visits – ideally between 6 and 10 – to minimise the potential loss.
8. Prescribers on home visits/working in the community should take suitable precautions to prevent the loss or theft of prescription forms. Keep them out of sight when not in use and do not leave any prescription forms in vehicles overnight.
9. Prescribers using the FP10PCD forms should exercise extra caution as there is greater potential for misuse of these forms.
10. Blank or signed prescription forms should never be left at patients' homes, care homes or community pharmacies for GP or locum visits.
11. Personalised forms which are no longer in use should be securely destroyed (e.g. by shredding) before being put into confidential waste, with appropriate records kept.
12. Spoiled or cancelled prescription forms should be retained for audit purposes.
13. In the event of a loss or theft of prescription form stock, local procedures should be followed and the practice manager/employer/non-medical prescribing lead, area team, Controlled Drugs Accountable Officer and the police should be notified as required. The incident should also be recorded on the organisation's incident reporting system. NHS Protect should also be notified at **[prescription@nhsprotect.gsi.gov.uk](mailto:prescription@nhsprotect.gsi.gov.uk)** using the form at annex B of the Security of prescription forms guidance document.

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<sup>29</sup> NHS Protect (2015) Security of Prescription Forms [Click Here](#)

## **Employer's responsibilities**

14. Develop a prescription security awareness culture amongst practice staff and prescribers.
15. Ensure that robust policies and procedures are in place to manage the effective security of prescription forms in the practice.
16. Designate a member of staff to accept overall responsibility for overseeing the whole process involved – from the ordering, receipt, storage and transfer of prescription forms to their overall security (including access to them).
17. Maintain an up-to-date list of all prescribers within the organisation to account for those who have left, moved employment/CCG area or been suspended from prescribing duties.
18. Check deliveries of prescription form stock from the supplier whilst the delivery driver is present, to check order and amount are correct and packaging is sealed and unbroken.
19. Report and investigate irregularities at delivery stage immediately with the supplier.
20. Transfer prescription form stock to secure storage immediately.
21. Ensure access to secure storage is restricted and all staff access to/from secure storage is recorded
22. Maintain clear and unambiguous records on prescription form stock received and distributed.
23. Patients, temporary staff and visitors should never be left alone with prescription form stock or allowed into secure areas where forms are stored.
24. Prescribers conducting home visits should be alerted to and be mindful of the potential dangers associated with carrying around prescription forms or leaving them unattended.
25. Personalised prescription forms which are no longer in use should be securely destroyed, e.g. by shredding, before putting into confidential waste.
26. Spoiled or cancelled prescription forms should be retained for audit purposes.
27. In the event of a loss or theft of prescription form stock, local procedures should be followed and the area team, Controlled Drugs Accountable Officer and the police should be notified as required. It should also be recorded on the organisation's incident reporting system. NHS Protect should also be notified at **prescription@nhsprotect.gsi.gov.uk** using the form at annex B of the Security of prescription forms guidance document.

**NB All of the above requirements highlight the need for clear channels of communication, both within and between organisations**

## **Annex D – Good Practice Example of Non-medical Prescribing Clinical Governance Frameworks**

### **Non-Medical Prescribing: An Outline Governance Framework for Local Organisations**

Adapted from document of the same name, written by M Cossey, North and East Yorkshire and Northern Lincolnshire SHA WDC and incorporating aspects of the Non-medical Prescribing Clinical Governance Framework written by L Wright and C Orme, Trent Strategic Health Authority; both first published in DH (2006) Improving Patients' Access to Medicines.

1. The development of non-medical prescribing (NMP) is a key policy initiative that aims to maximise benefits to patients and the NHS by:
  - providing better access to medicines and
  - better, more flexible use of the workforce skills
  
2. As paramedic prescribing is rolled out nationally it is important that all those involved understand the responsibilities of individual practitioners, managers and organisations in ensuring safe and effective implementation and practice of NMP. Ensuring patient safety is an integral part of all healthcare providers' clinical governance arrangements. Key steps for NHS organisations to have in place to ensure the implementation of clinical governance include:
  - Clear lines of responsibility and accountability for overall quality of clinical care
  - Development of quality improvement programmes
  - Management of risk
  - Clear procedures to identify and remedy poor performance.
  
3. This framework sets out the key elements that organisations and individual practitioners should have in place or be in the process of addressing, in order to ensure that the development of NMP is implemented within a mechanism that develops safe and effective practice. The framework should be read in conjunction with any policies and procedures that local organisations have in place for implementing NMP or any general policies related to prescribing and medicines management. It should also be read in conjunction with any national or professional guidance issued by the HCPC and the College of Paramedics

## 1. Organisational Leadership and Strategy for Non-medical Prescribing (NMP)

<p>Overarching statement: Clear lines of responsibility and accountability exist for all organisations in relation to the leadership, planning and implementation of NMP</p>	
<p>Governance arrangements required by organisations:</p>	<p>a) All organisations have a nominated named lead (or leads) for overseeing the development and implementation of NMP. Where different professional leads are in place co-ordination / networking between these leads is required to ensure consistency of approach to implementation and monitoring. The NMP lead should be linked directly with the Drugs and Therapeutics committee or equivalent. NMP should be linked into organisation prescribing and medicines management arrangements within the organisation where appropriate.</p>
	<p>b) Organisations should have in place an integrated policy around the strategic development and implementation of NMP. This should include: named leads for NMP, stakeholder and patient/public awareness initiatives, implementation plans for NMP, advice about training, internal arrangements for monitoring, mechanisms for application and training, processes for obtaining prescription pads, signposting to any relevant policies and procedures, and any other relevant local information.</p>
	<p>c) A co-ordinated database or register of all trained non-medical prescribers prescribing in that organisation should be maintained within all organisations. This database records all newly qualified prescribers; those employed by the organisation or another organisation commissioned to provide the prescriber and should note those NMPs who leave the organisation. It should also note the designated status of all NMPs (e.g. community practitioner nurse prescriber, independent/supplementary prescriber, supplementary prescriber) and the profession of the prescriber</p>
	<p>d) Systems are in place to inform non-medical prescribing lead in the Trust when new prescribers are employed and prescribers leave.</p>
	<p>e) A contact point within the organisation for any queries on the prescribing status of staff. i.e. from dispensing pharmacists</p>
	<p>f) Non-medical prescribing is an integrated part of organisational clinical governance arrangements and relevant action plans. Organisations must consider the impact of NMP on other related policies and procedures e.g. medicines-related error reporting.</p>

<p><b>Overarching statement:</b> Clear lines of responsibility and accountability exist for all organisations in relation to the leadership, planning and implementation of NMP</p>	
<p><b>Governance arrangements required by organisations (cont.):</b></p>	<p>g) All planned developments for NMP should be linked to strategic service development within the organisation For example: Long term conditions, improved access to medicines and services, practice based commissioning; service modernisation and redesign.</p>
	<p>h) Decisions to train individuals as NMPs should be linked to personal development plans and candidates should be assessed for competency related to knowledge and skills in their area of potential prescribing practice. the Competency Framework for all Prescribers is available from the Royal Pharmaceutical Society at <a href="https://www.rpharms.com/resources/frameworks/prescribers-competency-framework">https://www.rpharms.com/resources/frameworks/prescribers-competency-framework</a> (Note: it is not intended that individuals are competent to “prescribe” prior to training but organisations should be assured that practitioners have the necessary clinical skills and knowledge in their area of practice which will enable them to prescribe safely and effectively once trained <b>OR</b> that CPD and additional training is planned to ensure these can be met. Organisations should also check that individuals would meet the necessary Higher Educational Institute (HEI) entry requirements).</p>
	<p>i) All plans to train NMPs should also include an assessment of: service specification, access to a prescribing budget (or equivalent in acute trusts / secondary care), development of necessary policies or documentation e.g. clinical management plans (CMPs)</p>
	<p>j) Links should exist between NHS organisations, HEIs and Health Education England to ensure effective monitoring of applications, funding, and quality of training, monitoring of numbers and professions trained, and attrition rates from modules.</p>
	<p>k) Ongoing support and network arrangements are in place for all NMPs including discussion of NMP at annual appraisal and access to relevant CPD. Job descriptions are amended to account for prescribing responsibilities.</p>

## 2. Information governance and risk management of NMP

<p>Overarching statement: Clear policies exist or links to existing policies are explicit for all managers and NMPs in relation to information governance and risk management of NMP.</p>	
<p>Governance arrangements required by organisations: (See also 1c above)</p>	<p>a) All NMPs should be linked to all organisational systems to ensure prescribers are kept informed of relevant clinical, therapeutic and prescribing information e.g. BNF, MHRA alerts, Drug Safety Alerts etc.</p>
	<p>b) A risk management plan is in place which will ensure that potential risks associated with extending clinical practice are recognised and minimised</p>
	<p>c) NMP practice is monitored through the same routes as medical prescribing (e.g. ePACT data, audit and feedback in primary care, local mechanisms in acute Trusts) and that information is available to practitioners and managers where appropriate, in line with internal arrangements.</p>
	<p>d) The parameters of an individual's prescribing should be agreed between the prescriber, their manager or local professional lead (e.g. the non-medical prescribing lead), and their employer. This is best carried out using a personal formulary approach which is a continuation from that developed during the course of study. The formulary should include the context in which the non-medical prescriber will prescribe the medicine and how the knowledge and competence to prescribe the medicine was achieved and is being maintained/developed.</p>
	<p>e) All NMPs are aware of the importance, how to and are encouraged to report adverse drug reactions via the national Yellow Card system</p>
	<p>f) All NMPs understand the importance of reporting Serious Untoward Incidents and are aware of the local mechanisms for doing this as well as National Reporting and Learning System (NRLS) reporting.</p>
	<p>g) NMP should be aware of and adhere to the organisational policy regarding relationships with the Pharmaceutical Industry</p>
	<p>h) All record keeping guidance and protocols/templates for prescribing practice are updated regularly as detailed within PCT/Trust policies e.g. CMPs should be revisited and amended where necessary and at least annually</p>
	<p>i) All medical prescribers should be aware of NMPs within the organisation and when and how they may interact with</p>

<p><b>Overarching statement:</b> Clear policies exist or links to existing policies are explicit for all managers and NMPs in relation to information governance and risk management of NMP.</p>	
	patients to ensure consistency of record keeping and continuity of patient care.
	j) Organisations (including GP practices) should keep records of prescription pad numbers linked to prescriber name for tracking any lost or stolen prescriptions, where prescription pads are used
	k) Organisations should review their policies related to medico-legal accountability and information made clear to NMPs regarding accountability, vicarious liability and personal indemnity. (Practitioners should also be advised to contact their professional regulatory bodies).
	l) The names of prescribers are annotated on their professional register, before they begin to prescribe

### 3. Audit and Quality Improvement

<p><b>Overarching statement:</b> Mechanisms should be in place to include NMP in relevant audit. Audit cycles and review processes should be employed to ensure that the implementation and development of NMP is progressing in a safe and effective manner that is benefiting patients and services.</p>	
<p><b>Governance arrangements required by organisations:</b></p>	a) All review and updating of organisational prescribing and medicines supply policies include an impact assessment of NMP and are revised accordingly.
	b) All CMPs used by supplementary prescribers are reviewed (at least annually but more frequently where changes to patient's treatment plan, policy or evidence dictate) to ensure they are based on sound clinical evidence and are safe and cost effective.
	c) All NMP practice should be integral part of prescribing policy audit including adherence to NICE Guidance, other national or local clinical guidelines and any relevant local or national prescribing and medicines management policies.
	d) Evidence of tracking and monitoring arrangements should be in place to ensure the continuing competency of NMPs and their access to relevant, appropriate CPD. Systems should be in place to challenge competence issues.

#### 4. Patient and Public Involvement

Overarching statement: There should be mechanisms in place in organisations to ensure patients and public are aware of NMP practice and have a say in any related developments or audit of NMP services.	
<b>Governance arrangements required by organisations:</b>	a) Patients and the public should be made aware of any developments in NMP which may alter services in order that they can make informed choices and understand what NMP means for them and the delivery of their care.
	b) Methods to include patient and public comments in any NMP service review should be standard practice within all organisations
	c) Patient / public information should be available in all organisations outlining what NMP is, what it means for patients and any specific services where NMP is being used in that area.
	d) Patient / public involvement forums should be briefed about NMP where relevant and appropriate and information provided in a useable format.

#### 5. Responsibilities of Individual NMP practitioners and information resources

Whilst it is understood that organisations need to have robust governance arrangements in place for their NMP staff, individual practitioners have responsibility for ensuring they are clinically competent for their role, undertake appropriate CPD, practice within the law and any agreed local policies and abide by the HCPC Standards of Conduct, Performance and Ethics<sup>30</sup>

Standards of prescribing are available on the HCPC website<sup>31</sup> Guidance for prescribing practice are available from the College of Paramedics

The Competency Framework for all Prescribers, available from the Royal Pharmaceutical Society,<sup>32</sup> should be used by organisations, managers and individuals to assess competence to prescribe.

NICE currently purchases an annual supply of the British National Formulary and the British National Formulary for Children. Access to these resources is also available via 'Medicines Complete' and as an 'app' for mobile devices such as phones. Not all

<sup>30</sup> Health and Care Professions Council (2016) Standards of conduct, performance and ethics [Click Here](#)

<sup>31</sup> Health and Care Professions Council (2013) Standards for Prescribing [Click Here](#)

<sup>32</sup> Royal Pharmaceutical Society (2016) A Competency Framework for all Prescribers [Click Here](#)

prescribing professionals may need their own hard copy and may find electronic access more convenient,

The Drug Tariff is also available for reference on the BSA website<sup>33</sup>

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<sup>33</sup> <http://www.nhsbsa.nhs.uk/PrescriptionServices/4940.aspx>

## Annex E – Controlled Drugs

1. Paramedic Independent Prescribers can prescribe any licensed medicine for any medical condition, including, pending legislative change, some Controlled Drugs. Paramedic Independent Prescribers will be able to prescribe from the following list of Controlled Drugs.
2. Details of the appropriate route of administration for these Controlled Drugs can be found in the table below:

Medicine	Schedule	Route	Indication
Morphine	2 + 5	oral	Severe pain, palliative and end of life cancer care
Codeine	2 + 5	Parenteral and oral	Moderate/severe pain, Management of pain in palliative care
Midazolam	3	Parenteral	Anxiety Acute Pain. Sedation in end of life care, or similar presentations requiring palliation of agitation, with or without other problems i.e. pain
Lorazepam	4 part 1		Anxiety Conscious Sedation. Sedation associated with acute mental health disorder
Diazepam	4 part 1		Acute pain. Antispasmodic treatment of back pain and associated muscular spasm

3. Supplementary prescribers can, within their declared competence, prescribe any controlled drug from schedules 2 – 5 for any medical condition within their declared competence and by any route of administration that is included in a patient's clinical management plan and agreed by a doctor with the exception of diamorphine, cocaine and dipipanone for the treatment of addiction.
4. If it is within the paramedic prescriber's role and competence to prescribe scheduled and controlled drugs, the prescriber must agree this with the immediate line manager and inform the Non-medical Prescribing Lead and the Controlled Drugs Accountable Officer using the personal formulary or competency declaration route They must also be able to demonstrate:
  - Knowledge and understanding of the mode of action and pharmacokinetics of medicines, how these mechanisms may be altered (e.g. by age, renal impairment) and how this affects dosage
  - Knowledge and understanding of the potential for unwanted effects, (e.g. adverse drug reactions, dependency, drug interactions, allergy), and how to avoid/minimise and manage them

- Appreciation of the misuse potential of drugs
  - Application of the principles of evidence-based medicine, and clinical and cost-effectiveness
  - Understanding of the public health issues related to medicines and their use
  - Competence in the management of conditions to be treated,
5. In addition to the legal requirements for the prescribing and use of controlled drugs, knowledge of both local and national protocols for prescribing controlled drugs and other medicines with the potential for misuse.
  6. Some organisations may wish paramedic prescribers to undertake CPD e.g. MHRA Opioids e-learning programme or other resource prior to prescribing controlled drugs.
  7. The prescribing by paramedic prescribers of controlled drugs and other drugs with the potential for misuse such as hypnotics and anxiolytics will be closely monitored.
  8. The Misuse of Drugs Act and Human Medicines Regulations govern the prescribing of Controlled Drugs. For guidelines on the prescription of Controlled Drugs, healthcare professionals should refer to:
    - College of Paramedics: Practice Guidance for paramedic supplementary and Independent Prescribers, in particular practice guidance 25
    - Organisational controlled drugs policies and procedures
    - A guide to good practice in the management of controlled drugs in primary care, published by the National Prescribing Centre. [www.npc.co.uk](http://www.npc.co.uk)
    - Safer management of controlled drugs: a guide to good practice in Secondary Care [www.dh.gov.uk](http://www.dh.gov.uk)
    - The legal requirements for prescriptions for Schedule 2 and 3 Controlled Drugs are summarised in the BNF and the GPhC's publication, 'Medicines, Ethics and Practice: a guide for Pharmacists' (subscription only).
    - Section XVIIB of the Drug Tariff

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

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	No		
Your Clinical Role	Your employer provides clinical services which require independent prescribing (do 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.				<a href="#">HEE - definition of Advanced Practice</a>	
	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)					
	You have a qualification, experience and evidence of competency of diagnostics, physical examination and decision making skills relevant to your area(s) of prescribing practice.					

Topic	Evidence	Self-Assessment			Standards and Guidance Documents	Your Evidence
		Yes	Needs Development	No		
Your Organisation	You are employed by an organisation which is providing clinical services, and which has recognised a need for prescribing roles.					
	Your organisation has access to a pharmacist who is familiar with non-medical prescribing, and a Non-medical Prescribing Lead.					
	Your organisation has an established non-medical prescribing policy, governance processes, and prescribing budget which meet the minimum best practice standards					
	Your organisation employs a Medical Director or other Clinician delegated to oversee non-medical prescribing					
	Your organisation has sufficient access to a Designated Medical Practitioner (DMP) who meets the criteria (NPC, 2005), and who can supervise trainee non-medical prescribers.				<a href="#">Web Link - NPC 2005</a>	
Your Prescribing Education	You meet all educational requirements for entering an approved non-medical prescribing programme and you have experience and competence in using medicines legislation for administration, possession and supply of medicines					
	You have read and understood the Royal Pharmaceutical Society's competency framework				<a href="#">RPS - A Competency Framework for all Prescribers</a>	
	You have read and understood the Allied Health Professionals Federation Outline Curriculum Framework for independent and supplementary prescribing				<a href="#">AHPF Outline Curriculum Framework</a>	
	You have access to funding for non-medical prescribing education, or you are able to self-fund.					
	You have access to a DMP who can support your prescribing training					
Your CPD Plan and Opportunities	You have a detailed professional development plan which includes development as a prescriber. You can demonstrate attendance at relevant events, and a clear plan to take CPD opportunities in the future as a prescriber.				<a href="#">HCPC standards for continuing professional development.</a> <a href="#">HCPC Standards for Prescribing</a>	

Topic	Evidence	Self-Assessment			Standards and Guidance Documents	Your Evidence
		Yes	Needs Development	No		
Your Supervision Plan and Opportunities	You are able to identify a suitable non-medical prescribing supervisor (buddy system), and have liaised with your non-medical prescribing lead (if available) to discuss supervision needs.					
Your Local Prescribing Network	You are aware of your local prescribing network and have discussed with your non-medical prescribing lead the role and function of this group.					
Your Ongoing Role and Career Plans	A clinical role is part of your career plan and you should seek to undertake prescribing as a core aspect of your clinical career for at least 3 years					
	You understand the implications of ceasing to prescribe as part of your practice within your role.				<a href="#">HCPC - prescribing training</a>	
Your Regulator	You understand the guidance issued by your regulator (HCPC)				<a href="#">HCPC Standards for Prescribing</a>	
	You understand and follow the Standards of Performance, Conduct and Ethics issued by the HCPC				<a href="#">HCPC Standards of Conduct, Performance and Ethics</a>	
	You understand and follow the Standards of Proficiency for Paramedics issued by the HCPC				<a href="#">HCPC Standards of Proficiency for Paramedics</a>	
Your Professional Body's Practice Guidance	You understand the role of the professional body – the College of Paramedics, and understand its role in relation to practice guidance, indemnity, CPD and professional standards					
	You have read and understood the Practice Guidance issued by the College of Paramedics				<a href="#">College of Paramedics: Practice Guidance for paramedic supplementary and Independent Prescribers</a>	