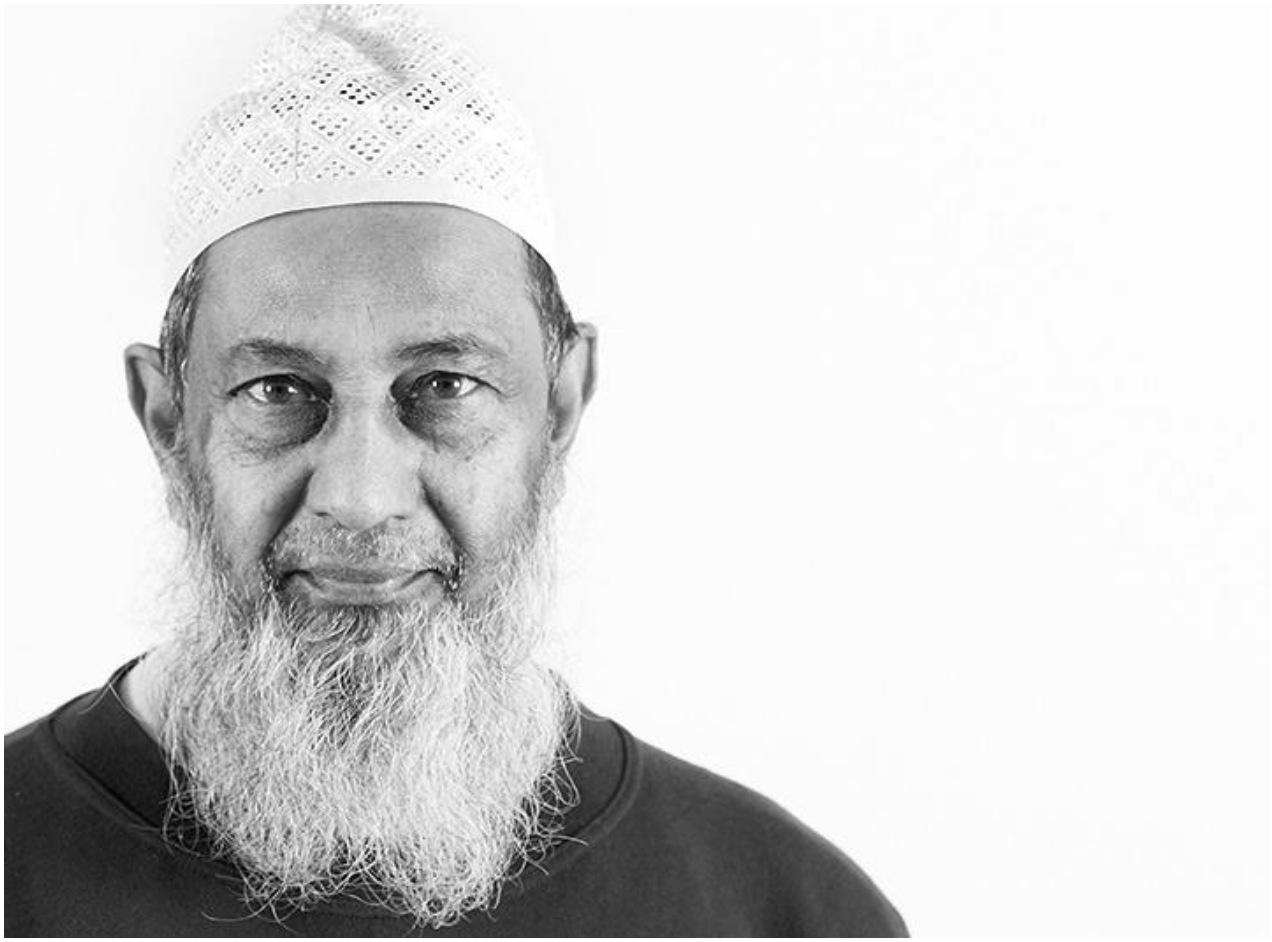

Summary of the responses to the public consultation on proposals to introduce independent prescribing by paramedics across the United Kingdom

Prepared by the Allied Health Professions Medicines Project Team

NHS England – February 2016

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Contents

1 Executive Summary

The purpose of this document is to provide a summary of responses received to the NHS England public consultation on proposals to introduce independent prescribing by paramedics across the United Kingdom.

It is recommended that this summary is read alongside the full consultation document which is available on the NHS England website here.

This summary document can also be requested in alternative formats, such as easy read, large print and audio. Please contact: enquiries.ahp@nhs.net

1.1 Outline of proposal

It was proposed that amendments to medicines legislation be made to enable advanced paramedics to independently prescribe medicines. The proposed changes to medicines legislation would apply throughout the United Kingdom in any setting in which paramedics work including the NHS, private, independent and voluntary sectors.

Five options for introducing independent prescribing by advanced paramedics within their scope of practice and competence were proposed:

Option 1: No change
Option 2: Independent prescribing for any condition from a full formulary
Option 3: Independent prescribing for specified conditions from a specified formulary
Option 4: Independent prescribing for any condition from a specified formulary
Option 5: Independent prescribing for specified conditions from a full formulary

It was also proposed that consideration be given to paramedic independent prescribers being permitted to mix licensed medicines prior to administration and be able to prescribe independently from the following restricted list of controlled drugs, within their scope of practice and competence.

- Fentanyl
- Morphine
- Codeine
- Midazolam
- Lorazepam
- Diazepam

1.2 Background to Consultation

- In 1999 the recommendations contained within the *Review of prescribing, Supply and Administration of Medicines*[1] informed policy for non-medical prescribing with the aim of improving: patient care, choice and access; patient safety; the use of health professional's skills; and flexible team working.

- In April 2010 the Department of Health (DH) Urgent and Emergency Care team undertook an informal stakeholder engagement exercise designed to inform the content of a future consultation on extension of prescribing rights to appropriately trained paramedics.

- In October 2013 the NHS England AHP Medicines Project team was established to take this work forward under the Chief Allied Health Professions Officer.

- A case of need for progression to independent prescribing by advanced paramedics was developed based on improving quality of care for patients, whilst also improving efficiency of service delivery and value for money.

- Approval of the case of need was received from NHS England's Medical and Nursing Directorate's Senior Management Teams in May 2014 and from the DH Non-Medical Prescribing Board in July 2014.

- In August 2014 Ministerial approval was received to commence preparation for a public consultation with devolved administration agreement.

1.3 Public consultation

NHS England led a 12-week public consultation between 26 February and 22 May 2015 on the proposal to introduce independent prescribing by Paramedics.

The proposed changes to medicines legislation would be applicable throughout the United Kingdom and the consultation was developed in partnership with the: Northern Ireland Department of Health, Social Services and Public Safety; the Scottish Department of Health and Social Care; the Welsh Department of Health and Social Services; the Department of Health for England; and the Medicines and Healthcare products Regulatory Agency (MHRA).

Notification of the consultation was published on the NHS England website with links provided on the College of Paramedics website. Respondents were able to submit their feedback via an online portal (Citizen Space), by email or in hard copy.

[1] Department of Health (1999) *Review of Prescribing, Supply & Administration of Medicines,* London. http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4077151

1.4 Summary of responses to the consultation

The 12-week public consultation received a total of 536 responses from across the United Kingdom.

- 88% (474) of responses were received from England.
- 4% (21) of responses were received from Scotland.
- 4% (21) of responses were received from Wales.
- 1% (6) of responses were received from Northern Ireland.
- 3% (14) of the respondents chose not to provide their country of residence.

90.7% of respondents (54 organisations, 430 individuals and 2 responses that did not identify whether they were responding on behalf of an organisation or as an individual) supported amendments to legislation being made to enable paramedics to prescribe independently.

Independent prescribing for any condition from a full formulary (option 2) was the preferred option for the majority of respondents, with 63% (43 organisations, 294 individuals and 1 response which did not state whether they were responding on behalf of an organisation or as an individual) in support of this option.

Support for the other options:

- 8.4% of respondents (1 organisation and 44 individuals) felt no change was needed (option 1).
- 13.68% of respondents (8 organisations, 64 individuals and 1 response which did not state whether they were responding on behalf of an organisation or as an individual) expressed a preference for independent prescribing for specified conditions from a specified formulary (option 3).
- 9.51% of respondents (2 organisations and 49 individuals) preferred independent prescribing for any condition from a specified formulary (option 4).
- 4.48% of respondents (1 organisation and 23 individuals) preferred independent prescribing for specified conditions from a full formulary (option 5).
- 0.93% of respondents (1 organisation and 4 individuals) did not answer.

77.6% of respondents (34 organisations, 380 individuals and 2 responses that did not identify whether they were responding on behalf of an organisation or as an individual) were also in agreement that paramedics should be able to prescribe independently from the proposed list of controlled drugs.

80.2% of respondents (50 organisations, 378 individuals, and 2 responses that did not identify whether they were responding on behalf of an organisation or as an individual) supported amendments to medicines legislation for paramedics who are independent prescribers to mix medicines prior to administration and direct others to mix.

1.5 Next steps

The results of the public consultation were presented to the Commission on Human Medicines for their consideration in October 2015 and their recommendations were published in December 2015, a summary of which can be accessed here.

The CHM did not support the proposal to introduce independent prescribing by paramedics at this stage on the grounds that it was felt that paramedics could potentially encounter a very wide range of conditions and it was not clear if they would have adequate training to assess, diagnose and prescribe appropriately for these conditions. The CHM also felt there was lack of clarity as to what constituted an advanced paramedic practitioner. The CHM therefore felt that at present independent prescribing by paramedics may represent a risk to patient safety.

NHS England continues to work collaboratively with the CHM, MHRA, DH and the College of Paramedics in taking the proposal forwards. Further updates on progress will be provided in due course.

2 Background

2.1 General information

There are 22,096 (as of February 2016) paramedics registered with the Health and Care Professions Council (HCPC) in the UK. Paramedics are first contact Allied Health Professionals (AHPs) who respond to 999 calls and are trained in all aspects of pre-hospital emergency care, ranging from acute problems such as cardiac arrest, strokes, spinal injuries and major trauma, to urgent problems such as minor illness and injury. Paramedics also work in other settings including GP practices, minor injury units, urgent care centres, walk-in centres and accident and emergency (A&E) departments, where they undertake full clinical assessments and make decisions regarding the care provide.

In recent years, the paramedic profession has evolved from a provider of treatment and transportation to a provider of mobile healthcare. This has required a greater focus on assessment, diagnosis, decision-making, treatment and where appropriate, onward referrals in line with changing patient profiles. Currently, less than a 1/3 of 999 calls made in England are for potentially life-threatening conditions[2]. The remaining 2/3 are from, or for patients with non-life-threatening conditions, including falls and exacerbations of long-term conditions.

2.2 Paramedic roles

Paramedic

Paramedics are autonomous, first contact practitioners and the term ‘paramedic’ is a protected title by law. All paramedics, whether working in the NHS, private or voluntary sectors must be registered with the HCPC through completing a HCPC approved education programme. At this level of practice, paramedics will receive supervision and mentorship from more senior and experienced paramedics within the workforce and undertake a period of preceptorship when first entering the profession. **Paramedics working at this level would NOT be eligible to undertake training to become independent prescribers if legislation was changed in the future.**

Specialist paramedic

Specialist paramedics are experienced autonomous practitioners who deliver a more complete level of assessment and care to patients with urgent, emergency, and unscheduled healthcare requirements. Their focus includes the care of acutely ill and/or injured patients at initial presentation, and those who present with an acute exacerbation of a chronic illness or disease. Specialist paramedics also have an important part to play in pre-hospital and out-of-hospital emergency medicine.

[2] Health and Social Care Information Centre (2015) *Ambulance Services, England 2014-15*, http://www.hscic.gov.uk/catalogue/PUB17722/ambu-serv-eng-2014-2015-rep.pdf

The College of Paramedics[3] considers the term 'specialist paramedic' to relate to those specialising in urgent and emergency care, critical care, research, education and other emergent areas.

Specialist paramedics have undertaken further higher education aligned with an area of clinical specialism. The College of Paramedics recommends that those working at a specialist level should be educated in a higher education environment to a minimum of postgraduate certificate or diploma level or equivalent, which is consistent with the recommendations of the *PEEP Report* [4]. **Paramedics working at this level would NOT be eligible to undertake training to become independent prescribers if legislation was changed in the future.**

Advanced paramedic

The College of Paramedics defines an advanced paramedic as an experienced paramedic who has undertaken, or is working towards a Master's Degree in a subject relevant to their practice. They will have acquired and continue to demonstrate an expert knowledge base, complex decision-making skills, competence and judgement in their area of advanced practice. The College of Paramedics definition is also in line with the recommendations of the *Paramedic Evidenced-Based Education Project (PEEP) Report* [5] and will appear in the College of Paramedics *Post Graduate Curriculum Guidance Document* which will be published in 2016.

Advanced paramedics are responsible for delivering safe, effective and appropriate treatment to patients with urgent, emergency and unscheduled healthcare requirements. They provide patients with a wide range of care and treatment, and are capable of 'seeing and treating' patients with complex needs in range of healthcare settings including walk-in-centres, urgent care centres, GP surgeries, A&E departments and the patients home. They will have developed and consolidated their specialist skills and capabilities to an advanced level, and will have a portfolio of evidence and expertise, including clinical leadership.

Following further higher education, advanced paramedics develop high level critical reasoning and diagnostic skills that enable them to independently assess and treat (where appropriate) patients with more complex presentations and care needs, including the acutely ill and those with exacerbations of long-term conditions. **If legislation was changed in the future ONLY paramedics working at this advanced level of practice or above would be eligible to undertake training to become independent prescribers.**

[3] College of Paramedics (2015) Paramedic *Post Registration Career Framework*, Bridgewater https://www.collegeofparamedics.co.uk/downloads/Post-Reg_Career_Framework_3rd_Edition.pdf:
[4] Lovegrove, M. (2013) *Paramedic Evidence-Based Education Project.* Buckingham: Allied Health Solutions. https://hee.nhs.uk/sites/default/files/documents/PEEP-Report.pdf
[5] Allied Health Solutions (2013) *Paramedic Evidence Based Education Project (PEEP) End of Study Report.* https://hee.nhs.uk/sites/default/files/documents/PEEP-Report.pdf

Consultant paramedic

Consultant paramedics must fulfil the criteria to hold an NHS consultant contract[6] and usually hold or are working towards a doctorate award. Core responsibilities include an organisational development role in areas of new and innovative clinical practice. Working at a strategic or executive level, they will be developing new care pathways while liaising with central health policy makers.

2.3 Where paramedics work

Although the vast majority of paramedics are employed in NHS ambulance services (84%)[7], they also work in the armed forces, the remote and offshore sectors, independent and private sectors, and in other non-ambulance service healthcare settings, including acute trusts, A&E departments, GP services, minor injury units, telehealth and telecare services, and alternative care pathway provider services.

As a result of the *Urgent and Emergency Care Review*[8] and the focus this brings around the importance of multidisciplinary teams, it is anticipated that the unique skill set of paramedics will be increasingly utilised within these teams and lead to the development of effective multidisciplinary one stop shops for urgent and emergency care provision, both in the community and wider healthcare setting.

2.4 Current use of medicines by paramedics

Paramedics have had a long relationship with medicines, which dates back over two decades. Under current medicines legislation, registered paramedics can supply and administer a range of medicines on their own initiative for the immediate, necessary treatment of sick or injured persons.

- **An Exemption** to medicines legislation allows the supply or administration of medicines, provided the requirements of any conditions attached to those exemptions are met.
- **A Patient Group Direction (PGD)** is a written instruction for the supply and/or administration of a licensed medicine (or medicines) in an identified clinical situation, where the patient may not be individually identified before presenting for treatment. Each PGD must be signed by both a doctor and pharmacist, and approved by the organisation in which it is to be used by a specified health care professional.

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[6] Department of Health (2005) *The National Health Service (Appointment of Consultants) Regulations: Good Practice Guidance*. https://www.rcseng.ac.uk/healthcare-bodies/docs/the-national-health-service-appointment-of-consultants-regulations

[7] Centre for Workforce Intelligence (2012) *Workforce Risks and Opportunities – Paramedics* http://www.cfwi.org.uk/publications/paramedics-workforce-risks-and-opporunities-education-commissioning-risks-summary-from-2012

[8] NHS England (2013) *Urgent and Emergency Care Review: End of Phase 1 Report*, http://www.nhs.uk/nhsengland/keogh-review/documents/uecr.ph1report.fv.pdf

- **A Patient Specific Direction (PSD)** is a prescriber's (usually written) instruction that enables a paramedic to supply or administer a medicine to a named patient.

In some clinical pathways, the scope of the existing legislation fits well with the needs of patients and enables optimal care. For example, current mechanisms for the supply and administration of medicines by paramedics work well for emergency patients with life-threatening conditions such as cardiac arrest or major trauma. However, in other pathways, such as the management of exacerbations of long-term conditions, falls and end of life care, existing legislation can limit the potential for paramedics to provide even greater benefits to patients and the delivery of optimal patient-centred care.

2.5 How paramedics are trained and regulated

The term 'paramedic' is a protected title by law and all paramedics, whether working in the NHS, private or voluntary sectors must be registered with the HCPC. The HCPC sets the standards that all paramedics have to meet in relation to their education, proficiency, conduct, performance, character and health. These are the minimum standards that the HCPC considers necessary to protect members of the public. Registrants must meet all these standards when they first register and complete a professional declaration every two years thereafter, to confirm they have continued to practise and continue to meet all the standards. The HCPC also regulates the fitness to practice and registration renewal of those already on the register, and has the powers to remove individuals from their register if they fall below the standards required to ensure public safety.

Historically, paramedics were trained through an in-service training model, the Institute of Health and Care Development (IHCD) programme, where typically an NHS ambulance trust delivered a skills-based course in-house. The majority of ambulance trusts consider this method of education outmoded and consequently, they have conversion programmes in place to ensure all paramedics have access to a Foundation Degree.

The vast majority of paramedic education across the UK now takes place in partnership between NHS Ambulance Trusts and 28 Higher Education Institutes (HEIs). The majority of HCPC approved paramedic training programmes across the United Kingdom, which currently lead to eligibility for registration with the HCPC as a paramedic are Foundation Degree or Bachelor Degree (with Honours) level. However, currently all programmes in Scotland, Wales and Northern Ireland are at DipHE/HND level or equivalent to Cert HE level.

Pre-registration education programmes leading to qualification as a paramedic include pharmacology and the administration of therapeutic medications, relevant to a paramedic's scope of practice, including pharmacodynamics and pharmacokinetics. Paramedics undertaking post-registration education programmes to work at a specialist and advanced level gain additional training in pharmacology, pharmacodynamics and pharmacokinetics, and condition and disease specific pharmacological interventions that are within their scope of practice.

The College of Paramedics have provided higher education institutions (HEIs) and other stakeholders with a comprehensive curriculum framework for the education and training of paramedics throughout the UK[9]. Paramedic graduate level education is supported by the *PEEP Report*[10] and the College of Paramedics is working closely with Health Education England and the Devolved Administrations to provide a UK-wide trajectory towards increasing the threshold level of qualification with the HCPC to degree level.

2.6 Continuing professional development (CPD)

Once registered, paramedics must undertake CPD and demonstrate that they continue to practise both safely and effectively within their changing scope of practice, in order to retain their registration. The HCPC sets standards which all registrants must meet. Registrants are required to maintain a continuous, up-to-date and accurate portfolio of their CPD activities, which must demonstrate a mixture of learning activities relevant to current or future practice. The portfolio declares how their CPD has contributed to both the quality of their practice and service delivery, whilst providing evidence as to how their CPD has benefited the service user.

The HCPC randomly audits the CPD of 2.5% of each registered profession on a 2 year cycle of registration renewal. Those registrants who are chosen for audit must submit a profile to show how their CPD meets the minimum standards of the regulator.

The College of Paramedics supports the HCPC in its requirement for paramedics to engage in CPD and makes recommendations to its members regarding CPD activities required to achieve the standards set by the regulator. Paramedics may use the HCPC and College of Paramedics frameworks to support their CPD requirements and to structure annual appraisal processes.

[9] College of Paramedics (2014) *Paramedic Curriculum Guidance* https://www.collegeofparamedics.co.uk/downloads/Paramedic_Curriculum_Guidance_2015.pdf

[10] Lovegrove, M. (2013) *Paramedic Evidence-Based Education Project.* Buckingham: Allied Health Solutions. https://hee.nhs.uk/sites/default/files/documents/PEEP-Report.pdf

2.7 Education and training for non-medical independent prescribers

Approved programmes for non-medical independent prescribers are currently multi-professional, with the training provided jointly for both independent and supplementary prescribers.

If legislation is changed in the future to enable advanced paramedics to train as independent prescribers, the HCPC will approve education programmes for the provision of paramedic independent prescribing training against their *Standards for Prescribing*[11].

Prescribing competence consists of many factors, from clinical assessment and diagnostic skills through to pharmacological knowledge. Individuals from all professions (nurses, pharmacists, optometrists, physiotherapists and podiatrists) begin prescribing training with different skills and expertise. However, in order to successfully complete a non-medical prescribing programme, *all prescribers* have to demonstrate a common set of competencies regardless of their professional background, as outlined in the *Single Competency Framework for all Prescribers*[12].

2.8 Eligibility for training as an independent prescriber

If legislation was changed to allow advanced paramedics to become independent prescribers, not all advanced paramedics would be expected to undertake the training. The safety of patients is paramount and the strict eligibility criteria for acceptance on independent prescribing education programmes are reflective of this.

In line with other AHP able to train as non-medical independent prescribers (e.g. physiotherapists and podiatrists), it was proposed that all paramedic entrants to the training programme would need to meet the following requirements:

- Be registered with the HCPC as a paramedic.
- Be professionally practising in an environment where there is an identified need for the individual to regularly prescribe independently.
- Be able to demonstrate support from their employer/sponsor*, including confirmation that the entrant will have appropriate supervised practice within the clinical area in which they are expected to prescribe.
- Be able to demonstrate medicines and clinical governance arrangements are in place to support safe and effective independent prescribing.

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[11] Health and Care Professions Council (2013) *Standards for prescribing*. London, HCPC http://www.hcpc-uk.org/publications/standards/index.asp?id=692

[12] National Prescribing Centre (now part of NICE) (2012) *A Single Competency Framework for all Prescribers*. http://www.webarchive.org.uk/wayback/archive/20140627111702/http://www.npc.nhs.uk/improving_safety/improving_quality/index.php

- Have an approved Designated Medical Practitioner (DMP) to supervise and assess their clinical training as a prescriber.
- Have normally at least 3 years relevant post-qualification experience within the clinical area in which they will be prescribing.
- Be working at an advanced practitioner or equivalent level.
- 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.
- In England and Wales, provide evidence of a Disclosure and Barring Service (DBS) check within the last three years. In Northern Ireland provide evidence of an AccessNI check within the last three years. 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.

2.9 How advanced paramedics would use independent prescribing if legislation was changed in the future

The proposal to introduce independent prescribing by advanced paramedics is part of a drive to make better use of their skills in providing a highly responsive service that delivers care as close to home as possible for patients with urgent care needs. The vision to develop 999 ambulance services into community-based mobile urgent treatment services[13] requires highly skilled paramedics with the ability to 'see and treat' more patients at the scene. This in turn requires paramedics to have appropriate prescribing responsibilities and access to medicines.

Advanced paramedics are highly experienced autonomous practitioners who are responsible for delivering safe, effective and appropriate treatment to patients with complex urgent, emergency and unscheduled healthcare requirements within a variety of healthcare settings. They must only work within this scope of practice and competence, and the same would apply if advanced paramedics were permitted to train as independent prescribers.

Due to the nature of paramedic practice, advanced paramedics throughout the course of their career will have managed high numbers of patients with a broad range of medical conditions and safely provided these patients with a range of medicines to treat these conditions using current mechanisms available to them. More importantly, this experience and increased knowledge allows advanced paramedics to have a greater understanding of the limits of their own practice and when it would be within their competence to prescribe and when they would need to seek further advice.

[13] NHS England (2013) *Urgent and Emergency Care Review: End of Phase 1 Report*, http://www.nhs.uk/nhsengland/keogh-review/documents/uecr.ph1report.fv.pdf

The examples provided below describe the way in which advanced paramedics could implement independent prescribing within their practice if permitted to train as independent prescribers in the future.

For example**:**

One in three people aged over 65 and half of those aged over 80, fall at least once a year[14]. The ageing population and proportion of older people being supported to live independently at home underpins the increased demand on ambulance services when these patients suffer a fall[15]. Falls can be the result of simple accidents, although many are caused secondary to minor health problems such as infections (e.g. urinary tract infections) which could, where appropriate be effectively treated by the paramedic independent prescriber at the scene. If introduced in the future, independent prescribing would therefore allow the advanced paramedic to consider a range of medicines appropriate to the clinical presentation without unnecessary onward referral or admission to hospital. This is particularly important for vulnerable older people who are at increased risk of infection, falls, depression and losses of both independence and confidence once admitted to hospital.

The *Urgent and Emergency Care Review – end of phase 1* report[16] highlighted the need for patients to be supported to self-care. Many patients effectively manage their long-term conditions at home but may experience exacerbations which necessitate additional support to continue to self-care. Paramedics are frequently despatched to patients with complex, albeit non-life-threatening conditions such as exacerbations of chronic illness in the community and are currently unable to optimise delivery of effective patient care at the scene, as they do not have access to appropriate prescribing mechanisms. A recent audit carried out by the College of Paramedics identified that as many as 7 out of 10 patients with respiratory tract infections that were seen by an advanced paramedic were not able to access the medicines required through current supply and administration mechanisms available to paramedics. if introduced in the future, independent prescribing would allow eligible paramedics to holistically consider a patient's needs and appropriately prescribe medicines where required and within their scope of practice. This would allow the patient to continue to self-manage at home, without unnecessary delay, admission to hospital or the need to be seen by an additional healthcare professional to access the medicines they need.

[14] Todd C, Skelton D (2004). What are the Main Risk Factors for Falls among Older People and What are the Most Effective Interventions to Prevent these Falls? *Health Evidence network report.* WHO Regional Office for Europe.

[15] Menon, L and Menon, G. (2011) *Falls in the Elderly.* *http://www.gponline.com/Clinical/article/1102509/falls-elderly/*

[16] NHS England (2013) *Urgent and Emergency Care Review: End of Phase 1 Report*: *http://www.nhs.uk/nhsengland/keogh-review/documents/uecr.ph1report.fv.pdf*

2.10 Benefits of independent prescribing by paramedics if legislation is changed in the future

If introduced in the future, independent prescribing by advanced paramedics can enable new roles and facilitate new ways of working to improve quality of care – delivering safe, effective services focussed on improving patient safety and experience. It would enable local service commissioners and providers to develop innovative local services in partnership with patients to meet the requirements of those with urgent care needs in the most cost-effective manner.

Furthermore, independent prescribing could support the development of new care pathways which will result in improved outcomes for patients by reducing delays in care and ensuring timely access to medicines needed whilst also improving patient experience through greater convenience and choice.

Patient safety could also be enhanced if independent prescribing by advanced paramedics was permitted by reducing mortality and morbidity through timely access to medicines whilst also ensuring clear lines of professional accountability and responsibility for prescribing decisions.

2.11 Use of antibiotics and antimicrobial stewardship

Advanced paramedics in urgent and emergency care already safely supply and administer a limited range of antibiotics within their scope of professional practice and competence under PGDs. They can also administer benzylpenicillin to treat Meningococcal Septicaemia in an emergency under exemptions to Schedule 19 of the Human Medicines Regulations 2012.

All healthcare workers have a vital role to play in preserving the usefulness of antimicrobials by controlling and preventing the spread of infections that could require antibiotic treatment. NICE Guideline NG15 *Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use*[17] provides detailed recommendations for both organisations (commissioners and providers) and individual health and social care practitioners, regarding the use of antibiotics and antimicrobial stewardship. Like all healthcare providers' paramedics and their employing organisations are required to consider antimicrobial stewardship and follow national and local policies and guidelines for antibiotic use.

[17] National Institute for Health and Care Excellence (NICE) (2015) Guideline NG15: *Antimicrobial stewardship: systems and processes for effective antimicrobial medicines use:* https://www.nice.org.uk/guidance/ng15/resources/antimicrobial-stewardship-systems-and-processes-for-effective-antimicrobial-medicine-use-1837273110469

3 Consultation Process

3.1 General

The proposed changes to medicines legislation would apply throughout the United Kingdom and therefore the consultation was developed in partnership with; the Northern Ireland Department of Health, Social Services and Public Safety; the Scottish Department of Health and Social Care; the Welsh Department of Health and Social Services; the Department of Health for England; and the Medicines and Healthcare Products Regulatory Agency.

The UK-wide consultation was held between 26 February and 22 May 2015.

3.2 Communications

Invitations to respond to the public consultation were sent to the Chief Executives of NHS Trusts, Clinical Commissioning Groups, Royal Colleges, Healthcare Regulators and other national professional organisations. Medical Directors, Directors of Public Health, Directors of Nursing, Directors of Adult Social Services, and NHS England Regional and Area Directors also formed part of the target audience.

Organisations and groups with an interest were contacted including third sector organisations, patient groups, arm's length bodies and NHS networks.

NHS England also undertook engagement meetings with a number of Royal Colleges and Professional Bodies during the consultation period to support them responding to the consultation. Notification of the consultation was published on the NHS England website with links provided on the College of Paramedics website.

3.3 Methods

Responses to the consultation were received in either one of the following ways:

1. By completing the online consultation on the NHS England Consultation hub website.
2. By downloading a PDF copy of the reply form from the NHS England Consultations webpage and emailing the completed from to the AHP consultation mailbox
3. By printing the reply from or requesting a hard copy to complete and return by post.

The consultation documents were also available in alternative formats, such as easy read, Welsh language, and large print or audio upon request.

3.4 Patient and public engagement

During the consultation period public and patient engagement events were held in England, Scotland and Northern Ireland.

The events were an opportunity for patients, carers and the public to develop their understanding of the four proposals being taken forwards as part of the AHP Medicines Project and which included:

- Independent prescribing by radiographers
- Independent prescribing by paramedics
- Supplementary prescribing by dietitians
- Use of exemptions by orthoptists

Attendees had an opportunity to take part in small group discussions and ask questions in order to seek clarity on the proposals.

An event was not held in Wales as it was decided by the Welsh Government that the communications strategy they already had in place was sufficient and therefore did not warrant further engagement.

3.5 Equality and health inequalities

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services, and to ensure services are provided in an integrated way where this might reduce health inequalities.

The extension of medicines mechanisms aims to improve patients' access to the medicines they need in a variety of settings. It may specifically benefit and reduce barriers in access to medicines for different equality groups included in, but not restricted to those included in the Equality Act 2010:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

Additionally, other specific groups should be considered when developing policy, including: children and young people, travelers, immigrants, students, the homeless and offenders.

The impact of the proposal on equality and health inequalities were addressed twofold:

1. As part of the patient and public engagement exercises (see section 3.4) a health inequalities table-top discussion was held to gain feedback from participants and consider the impact of proposed changes on all of the above protected characteristics and specific groups.

2. Two questions were posed as part of the public consultation to identify any impact on the protected characteristics and specific groups (see section 3.6).

It can be concluded from the responses to the consultation that changes to legislation to allow independent prescribing by paramedics would have a positive impact on many of the protected characteristics and groups but no negative impact on any individual characteristic or group.

3.6 Consultation questions

Respondents to the consultation were required to give their name and email address as well as responses to the following questions:

Question 1: Should amendments to legislation be made to enable paramedics to prescribe independently?

Question 2: Which is your preferred option for the introduction of independent prescribing by paramedics?

Question 3: Do you agree that paramedics should be able to prescribe independently from the proposed list of controlled drugs?

Question 4: Should amendments to medicines legislation be made to allow paramedics who are independent prescribers to mix medicines prior to administration and direct others to mix?

Question 5: Do you have any additional information on any aspects not already considered as to why the proposal for independent prescribing SHOULD go forward?

Question 6: Do you have any additional information on any aspects not already considered as to why the proposal for independent prescribing SHOULD NOT go forward?

Question 7: Does the ‘Consultation Stage Impact Assessment’ give a realistic indication of the likely costs, benefits and risks of the proposal?

Question 8: Do you have any comments on the proposed practice guidance for paramedic prescribers?

Question 9: Do you have any comments on the ‘Draft Outline Curriculum Framework for Education Programmes to Prepare Paramedics as Independent Prescribers’?

Question 10: Do you have any comments on how this proposal may impact either positively or negatively on specific equality characteristics, particularly concerning: disability, ethnicity, gender, sexual orientation, age, religion or belief, and human rights?

Question 11: Do you have any comments on how this proposal may impact either positively or negatively on any specific groups, e.g. students, travellers, immigrants, children, offenders?

4 Consultation Responses

The consultation received 536 responses in total. 528 responses were received via the online portal (Citizen Space), and 8 were received in hard copy.

Responses were received from all four countries of the UK as outlined in table 1 below:

Responses by Country	Number of responses received
England	474
Scotland	21
Northern Ireland	6
Wales	21
Not answered	14
Total responses	**536**

Table 1: Breakdown of consultation responses by country

56 organisations responded to the consultation and 478 responses were received from individuals of whom 92 were from patients, carers and members of the public, while 386 responded as a health or social care professional including: doctors, nurses, pharmacists and Allied Health Professionals.

Responses by individuals	**478**
Healthcare professionals	386
Public, carers/patients	92
Responses by organisations	**56**
Did not state if responding as an individual or organisation	**2**
Total responses	**536**

Table 2: Breakdown of respondents

The responses were categorised into 6 groups as outlined in table 3 below; groups 1 to 5 comprise all of the organisational responses, sorted by organisation type while the 6th group includes all individual responses.

Group 1	National Organisations and Networks; Professional Bodies and Royal Colleges; Regulators; Government & Arm's Length Bodies
Group 2	Allied Health Professional Organisations, Professional Bodies and Advisory Groups
Group 3	Educational Bodies/Establishments
Group 4	Commissioning; Commercial and Non-Commercial organisations; Service Providers; Independent Sector; and Trade Associations
Group 5	Patient and Public Representatives; Charitable and Voluntary Associations
Group 6	Individual responses

Table 3: Organisational Groups

Appendix A lists all organisational responses to questions 1, 2, 3 and 4 as these questions were directly related to the proposal with the remainder being related to the supporting documents and the impact of the proposal on equality and health inequalities.

4.1 Summary of responses by question

4.1.1 Responses to question 1

1) *Should amendments to legislation be made to allow paramedics to independently prescribe?*

Response options:

- Yes
- No

96% (54) of organisations and 90% (430) of individuals supported the proposal.

The breakdown (number and percentage) by group can be seen in table 4 overleaf.

	Organisations												Individuals		Other responses *	
	Group 1		Group 2		Group 3		Group 4		Group 5		All Organisations		Group 6			
Option		%		%		%		%		%		%		%		%
Yes	14	93	9	100	9	100	21	95	1	100	54	96	430	90	2	100
No	1	7	0	0	0	0	1	5	0	0	2	4	47	10	0	0
Not answered	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Total	15	100	9	100	9	100	22	100	1	100	56	100	478	100	2	100

*did not say whether they were responding on behalf of an organisation or as an individual

Table 4: Breakdown by groups for responses to question 1

96% (54) of organisations and 90% (430) of individuals supported amendments to legislation being made to enable paramedics to prescribe independently with overwhelming reference being made to the impact this would have on improving patient care and supporting the redesign of urgent and emergency care services.

A selection of some of the comments received from respondents who **agreed** to legislative change are shown below.

> *Paramedics play a vital role in the acute care pathway. Enabling advanced paramedics to independently prescribe will enable more patients to be treated in their own home and open up more roles in different care settings for the paramedics. This in time has potential to decrease pressures on existing emergency and primary care services.* **The Royal College of Emergency Medicine**

> *We strongly support a move to independent prescribing for appropriately trained advanced paramedics. Would allow easier access to appropriate medications for patients. Key benefits: Increased ability for paramedics to treat an acute problem at home rather than convey to hospital or refer on to a GP seems the key one, including extended role use in urgent care/OOH service. Increased autonomy and flexibility in administering medications in appropriate emergency situations. In addition, it would support the development of the paramedic profession.* **British Association of Immediate Care (BAsICs)**

> *Yes. It seems eminently sensible to permit a wider group of regulated, highly qualified, trained professionals to prescribe. They are the experts in their respective fields. Experience has been that independent and supplementary prescribing by other groups of non-medical professionals is safe, cost-effective and benefits patients.* **Public Health England**

> *Paramedics are a regulated profession and should have ability to prescribe independently, within their competencies, as is the case for other health professions.* **Controlled Drugs Accountable Officers' Network Scotland**

Yes. The evidence from other professions where independent prescribing has been introduced is that it facilitates patients' timely access to appropriate medicines, particularly compared to relatively inflexible mechanisms such as patient group directives (PGDs) and patient specific directions (PSD). Paramedics are a vital part of moves across the UK to provide urgent care for patients as close to home as possible. Appropriate prescribing responsibilities are a core part of being able to achieve the aspiration to have paramedics who are able to 'see and treat' patients at the scene, delivering timely and effective care and helping to reduce unnecessary admissions to hospital and pressure on A&E. Prescribing responsibilities would also enable paramedics to take on new roles in primary care, giving more patients access to care and treatment close to home. **Council of Deans of Health**

This is in line with the current drive to manage more patients closer to home. Countless policy and strategic documents have highlighted this direction of travel and as such not to enable this would be counter intuitive. **East Midlands Ambulance Service**

We support amendments to legislation. The benefits of this proposal are that patients would be able to obtain the medicines they need when and where they need them, improving outcomes. There would also be a reduction in the number of clinicians necessary to access prescriptions which will make the process smoother. The changes would support service redesign and innovation to prevent avoidable admission, thereby improving care for patients. **Allied Health Professions Federation (AHPF)**

It would benefit patients if paramedics could prescribe in emergency situations (e.g. as ambulance crew), or in other contexts where paramedics work (e.g. health centres, walk-in centres, A&E), where seeing a doctor for a script would be time consuming. **Healthwatch Bolton**

Increasing proportions of contacts for the NHS Ambulance Service are for problems that could be managed by appropriate 'at scene' assessment, often with a prescribing decision, which will minimise the impact on the wider health service, free up other prescribing clinician time and minimise delays until effective treatment. **Doctor**

Paramedic education has come a long way in recent years, the new breed of specialist Paramedics would be excellently placed to prescribe. Allowing them to do so would reduce pressure on A&E departments, GP's, out of hours GP services and ultimately save the NHS time and money. **Paramedic**

Paramedics are already called to many urgent care cases and spend time on scene liaising with other agencies (social services, GPs, community nursing, community mental health teams) to organise a better pathway for care. Paramedics are highly-skilled clinicians, registered healthcare professionals and should be permitted to prescribe some drugs. It removes the likelihood of an emergency response being called for this patient again in the near future and as other care pathways are limited by government cuts, more pressure falls on ambulance services as the frontline of the national healthcare system. Paramedics are already giving clinical advice over the phone to ease pressure on our services, they should be given further reasonable steps to deal with these pressures. **Member of the Public**

4% (2) of organisations and 10% (47) of individuals who responded were **not** supportive of legislative change. Their comments covered a perceived deficiency in the underlying background knowledge, education and training of paramedics, and access to a patient's medical history.

Have concerns on paramedics having access to the patient's full medical and drug history to be able to safely prescribe new medicines with the normal that are prescribed and administered as part of their agreed and recognised role... **NHS Ayrshire and Arran**

Acute responders dealing with acute emergencies. They are not best placed to diagnose; they do not have the correct training or experience. **Doctor**.

Insufficient training in Pharmacology. **Patient**

Dilutes core role of Paramedics. Other AHPs are better suited to meet primary care needs. **Patient**

They simply lack the necessary physiological and pharmacological knowledge to do this safely. **Doctor**

Daily experience has shown significant problems with communications from paramedics to GP. I feel it devalues and dilutes the particular skill mix of paramedics to add this. To rely on the patient's account of medication without access to medical records is dangerous, as is their inability to access information regarding tests, e.g. renal function. Accessing medication at home in this way encourages patients to 'patch up' their Health, rather than access help in a way that supports longer-term decision-making. **Doctor**

4.1.2 Responses to question 2

2) Which is your preferred option for introducing independent prescribing by paramedics?

Option 1: No Change
Option 2: Independent prescribing for any condition from a full formulary
Option 3: Independent prescribing for specified conditions from a specified formulary
Option 4: Independent prescribing for any condition from a specified formulary
Option 5: Independent prescribing for specified conditions from a full formulary

2% (1) of organisations and 9% (44) of individuals chose option 1.

76% (43) of organisations and 62% (294) of individuals preferred option 2.

14% (8) of organisations and 13% (64) of individuals preferred option 3.

4% (2) of organisations and 10% (49) of individuals preferred option 4.

2% (1) of organisations and 5% (23) of individuals preferred option 5.

The breakdown (number and percentage) by group can be seen in table 5 below.

	Organisations												Individuals		Other responses *	
	Group 1		Group 2		Group 3		Group 4		Group 5		All Organisations		Group 6			
Option		%		%		%		%		%		%		%		%
Option 1	0	0	0	0	0	0	1	5	0	0	1	2	44	9	0	0
Option 2	11	73	8	89	9	100	15	68	0	0	43	76	294	62	1	50
Option 3	1	7	1	11	0	0	6	27	0	0	8	14	64	13	1	50
Option 4	2	13	0	0	0	0	0	0	0	0	2	4	49	10	0	0
Option 5	0	0	0	0	0	0	0	0	1	100	1	2	23	5	0	0
Not answered	1	7	0	0	0	0	0	0	0	0	1	2	4	1	0	0
Total	15	100	9	100	9	100	22	100	1	100	56	100	478	100	2	100

*did not say whether they were responding on behalf of an organisation or as an individual

Table 5: Breakdown by group for responses to question 2

Option 1: No change

The responses below illustrate the concerns raised around independent prescribing by paramedics which relate to the breadth of paramedic scope of practice; risks to patient safety and competencies, skills and training.

> *Have concerns on paramedics having access to the patient's full medical and drug history to be able to safely prescribe new medicines outside the normal that are prescribed and administered as part of their agreed and recognised role…* **NHS Ayrshire and Arran**
>
> *Safety and quality control issues. I am truly shocked that full formulary has even been considered and this is something that the proposed training structure on the background of paramedic training is not designed to cope for and is not fit*. **Member of the public**
>
> *PGDs are appropriate, no need to extend to prescribing rights.* **Nurse/Heath Visitor**
>
> *They are already able to give emergency interventions. A wider remit would require significantly increased training and reduce the ability to focus on what they already do well.* **Doctor**

Option 2: Independent prescribing for any condition from a full formulary

Comments in support of this option made particular reference to ensuring that the impact of independent prescribing on patient care is maximised by allowing paramedics the flexibility to prescribe within their scope of practice and competence, the need for alignment with other non-medical independent prescribers and the impracticalities of applying unnecessary limitations.

> *This is to allow full patient care to take place both within the community and hospital both in urgent and emergency care. This would ensure parity with other health professionals, develop professional prescribing and enhance patient care at point of need.* **The Royal College of Surgeons of Edinburgh Faculty of Pre Hospital Care - Paramedic Advisory Group**
>
> *Paramedics should be no different from other AHPs.* **The Royal College of Emergency Medicine**

…We would like to revise our position and response to the option re. paramedic independent prescribing on behalf of NASMeD and the Association of Ambulance Chief Executives (AACE). Our preferred option is independent prescribing for any condition from a full formulary. We now feel assured that trusts will be able to develop their own formularies and this work could be undertaken by NASMeD/AACE to ensure a coordinated approach is taken amongst ambulance trusts. We are also reassured that a paramedic as an independent prescriber will also be encouraged to have a personal formulary. We appreciate that ambulance trusts as employers will be able to use their trust formularies to monitor prescribing practice and ensure that prescribing is well governed and safe… **National Ambulance Service Medical Directors/Association of Ambulance Chief Executives***

**Initially the National Ambulance Service Medical Directors (NASMeD)/Association of Ambulance Chief Executives (AACE), expressed a preference for Option 3. However, NHS England received a revised position statement from NASMeD/AACE requesting that their preferred option be changed from Option 3 to Option 2*.

This option enables a future focus, allowing for developments and innovation in practice. The other options would be very restrictive. The prescribing paramedic's employer can put governance restrictions in place as necessary regarding level of paramedic, expertise and scope of practice. **Health Education North West**

Although we agree that this option we wish to stress that prescribing of any medicine for any condition must be within their professional scope of practice/competence. **Guild of Healthcare Pharmacists**

We support Option 2 (independent prescribing for any condition from a full formulary). A restricted formulary or list of conditions would reduce the flexibility for paramedics to respond to patients' needs (2/3 of which would be urgent care), reducing the potential benefit to patient outcomes of paramedic prescribing. **Council of Deans of Health**

Paramedics are a regulated profession with training and governance. Legislation should allow the future development of this role, so whilst prescribing may be restricted dependant on individual competency and area formularies, e.g. SAS there should be the legal recognition that paramedics should be able to prescribe any drug for any condition. **Controlled Drugs Accountable Officers' Network Scotland**

We believe it is the most appropriate option in that it would be most effective in improving the experience of patients and service users. Other options, such as prescribing for specific conditions or from a list of specified medicines, could limit the number and types of patients who benefit. **Health and Care Professions Council (HCPC)**

This supports the Scottish Government's 2020 vision, it may reduce unnecessary hospital admission and allow timely access to treatment. It is important that unnecessary restrictions are not applied, rather that paramedics prescribe within their competency. Timely access to treatment, particularly as paramedics often work in isolation, should not be compromised. There must however be appropriate governance arrangements for prescribing, robust clinical supervision arrangements for independent prescribers, and initial and ongoing education, training and competence assessment. **Scottish Directors of Pharmacy**

The generalist nature of the Paramedics role illustrates they deal with all patients, in all age groups with a wide range of presenting illness and injury. To choose any other option than option 2 will only leave limits in expanding the paramedics practice and having to be revisited at a later date. **East Midlands Ambulance Service**

Paramedics would be permitted to independently prescribe any medicine for any condition, within their professional scope of practice and competence. The responsibility for prescribing within competence sits with the Paramedic and this option is consistent with other non-medical independent prescribers. **College of Paramedics**

Paramedics see a wide range of medical conditions which may benefit from prescription medicines, which are unavailable to paramedics at present. This would prevent overload on Out of hours GP surgeries, particularly over the weekend period. Specifying conditions may prevent patients getting the correct treatment in the most appropriate environment, i.e. at home. **Prime Care Ambulance Service**

I think we need to learn from the introduction of NMPX for nurses where limiting the formulary and conditions associated led to confusion and inhibited practice and gains that could have been achieved if the emphasis is on competence of the practitioner. Managers need to carefully select appropriate staff to undergo the programme who are experienced. It should also be noted that a number of paramedics are now working in advanced clinical roles within hospital settings as well as working in traditional paramedic roles. **Nurse/Health Visitor**

Option 3: Independent prescribing for specified conditions from a specified formulary

The comments received referred to the need for a limited formulary and limited list of conditions in order to safeguard patients.

> *NIAS favours this option as this model demonstrates greatest safety for patients and paramedic prescribers. It is important that prescribing fits within existing agreed emergency and urgent care pathways and does not conflict with other previously agreed regimes. Access to patient records via an electronic care record is essential to achieve this.* **Northern Ireland Ambulance Service**

> *The paramedic profession is a young and continually developing profession…At this stage, it appears to be a huge stepwise change for APPs to move from relatively constrained practise, to a full formulary for any condition.* **Welsh Ambulance Service NHS Trust**

> *Paramedics have a narrow focus of training and a limited scope of practice. Therefore, it would be inappropriate and unnecessary for paramedics to have unfettered prescribing authority.* **NEMS CBS Ltd**

> *Specified conditions as some are easily recognised by training from paramedics, however, if opened up to any conditions, this would easily undermine primary care physician's roles and the purpose of training through medical school, Foundation Years and the Speciality Training programme. The same principal also applies to specified formulary, as primary care physicians are likely to be better placed to recognise interactions, side effects, and alternatives when allergies or intolerances are noted.* **Medway CCG**

> *An unrestricted formulary for practitioners with a limited sphere of training, experience and working remit is not appropriative. In addition, prescribing for conditions that would normally require a doctor to be involved due to the complexity or advanced decision-making would be inappropriate. Therefore, a specified list of conditions and a set formulary is the most appropriate compromise between ensuring appropriate treatment can be given in the timeliest way, without the restrictions of PGDs etc., but ensuring safety*. **Doctor**

> *Paramedics need to be given more autonomy, but this needs to be on an incremental basis initially. Following audit and review, if practice is successful then prescribing responsibilities can be extended.* **Paramedic**

> *Start with most common situations where most benefit can be demonstrated, can extend the law and practice if needed, when audited, later.* **Pharmacist**

It could be unreasonable for paramedics to have a full understanding of all medical conditions and drugs. Having an in-depth knowledge of the most common conditions and their relevant drug treatments would be safer. Unless they have access to instant medical advice to help with prescribing to patients with more unusual conditions. **Member of the Public**

Option 4: Independent prescribing for any condition from a specified formulary

Comments included a feeling that a stepwise approach/phased implementation would be most appropriate to ensure patient safety.

Although we support the development of paramedic prescribing, the potential roles of paramedics are increasingly wide and diverse. We would recommend a stepwise approach. Initially a specified formulary would seem appropriate and mitigate risk that may, or may not, materialise with experience. Key current need as outlined in the document is for acute medications for acute conditions or exacerbations of long-term conditions. Experience gained in this initial development could inform development of wider prescribing if the need was demonstrated. The stated limitations of the difficulty in maintaining lists of specified medications could be mitigated by limiting to groups of medications rather than a list of individual medications. **British Association for Immediate Care (BASICS)**

Basic paramedic training prepares a paramedic to deliver emergency care. Specialist practitioners may undertake further programmes of study but this does not equip them to prescribe safely from a full formulary as an independent prescriber. Furthermore, it is a significant step from working within the boundaries of a PGD, where others have assessed and mitigated the risk inherent in the supply and/or administration of a medicine, to taking full clinical responsibility for independent prescribing. In the interest of patient safety, prescribing should be limited initially to those medicines already familiar to paramedics working in urgent care settings. However, specifying the condition may be more difficult, particularly for antimicrobials, where prescribing guidance may change to reflect local resistance patterns. **Pharmacist**

I think for the introduction phase it will be safe to treat any condition with a list of specified formulary. I think this should be extended to full formulary in the future, however, in the earlier phase specifying a formulary will probably help reduce unnecessary use of drugs. **Paramedic**

A lot of medications including antibiotics and analgesics are used acutely. Most other medications do not need to be prescribed urgently and the patient could therefore be seen by their GP for review and a full set of notes would be available. **Doctor**

A specified formulary ensures that paramedics will be appropriately familiar with the drugs that they are allowed to prescribe. **Doctor**

Paramedics already have the ability to administer medications under a PGD, exemption and this is already updated at regular intervals. The environments that paramedics currently work within are mainly unscheduled care with minimal follow up and so the ability to prescribe chronic care medications without follow up could be dangerous for the patient. **Nurse/Health Visitor**

I believe Paramedics should have a limited number of medications that they can prescribe for any condition. Over time I think this should then be developed a little further. To use a full formulary for all conditions would be too much, and without doing pharmacology degree I do not think that training would be adequate enough to cover this. **Paramedic**

Option 5: Independent prescribing for specified conditions from a full formulary

The comments highlighted that this option would also allow for a stepwise approach or phased implementation to ensure patient safety (as with option 4), but that option 5 would reduce the risk of a restricted formulary becoming outdated.

Would prefer option 5 over option 4, because the specified formulary might become outdated as new drugs become available. **Healthwatch Bolton**

This would be a good starting point with a view to extending the scope over time. **Paramedic**

Paramedics cannot be expected to be able to manage all conditions so limit prescribing to those they are competent to manage and will see commonly, this will maximise benefit and limit risk. **Nurse/Health Visitor**

This again would mean the patient would receive a more efficient service without unnecessarily tying up other health care professional's time. **Member of the Public**

The average paramedic in this country has received minimal training in health assessment and decision-making. The traditional preparation for practice has been focussed on the minority of patient conditions (heart attack, cardiac arrest, significant injuries) using the service, rather than the majority in contemporary practice, e.g. frail elderly, co-morbid, or minor ailments. The move in recent years to degree status will have helped increase paramedic knowledge but there is still a long way to go to achieve critical mass of paramedics with appropriate health assessment and decision-making acumen. **Nurse Health Visitor**

4.1.3 Responses to question 3

3) *Should paramedics be able to prescribe from a restricted list of controlled drugs, subject to separate amendments of appropriate Regulations?*

Response options:

- Yes
- No
- Partly

The proposed list of controlled drugs:

- Fentanyl
- Morphine
- Codeine
- Midazolam
- Lorazepam
- Diazepam

61% (34) of organisations and 79.5% (380) of individuals agreed with changes being made to legislation to allow paramedics to prescribe independently from the proposed restricted list of controlled drugs.

27% (15) of organisations and 10% (48) of individuals partly agreed.

11% (6) organisations and 10% (48) of individuals disagreed with this aspect of the proposal.

1% (1) of the respondents did not state whether they were responding on behalf of an organisation or as an individual.

The breakdown (number and percentage) by group can be seen below in table 6.

	Organisations												Individuals		Other responses *	
	Group 1		Group 2		Group 3		Group 4		Group 5		All Organisations		Group 6			
Option		%		%		%		%		%		%		%		%
Yes	8	53	8	89	7	78	10	45	1	100	34	61	380	79.5	2	100
No	3	20	0	0	0	0	3	14	0	0	6	11	48	10	0	0
Partly	3	20	1	11	2	22	9	41	0	0	15	27	48	10	0	0
Not answered	1	7	0	0	0	0	0	0	0	0	1	1	2	0.5	0	0
Total	15	100	9	100	9	100	22	100	1	100	56	100	478	100	2	100

*did not say whether they were responding on behalf of an organisation or as an individual

Table 6: Breakdown by group for responses to question 3

Of the comments received from those who **agreed** that paramedics should be able to independently prescribe from the proposed list of controlled drugs, it was generally felt that in line with other non-medical prescribers, the proposed list of controlled drugs would support paramedics to deliver improved patient care when used within their scope of practice and competence and with appropriate governance in place.

The number of controlled drugs listed in each schedule is relatively small but sufficiently adequate to treat the conditions expected in urgent care cases. **Guild of Healthcare Pharmacists**

Restrictions should be in place to avoid prescription of controlled drugs in situations of potential misuse of these drugs. These would protect the paramedic from possible pressure from patients to prescribe these. **Royal College of Physicians of Edinburgh**

Contemporary paramedic practice is heavily reliant on the use of a range of controlled drugs for the provision of effective analgesia and/or sedation for the treatment of traumatic injuries, severe pain, acute behavioural disturbance and end of life care. Existing legislation permits paramedics to administer a limited range of controlled drugs. This history of controlled drug use coupled with positive audit and research data suggests that paramedics are capable of using controlled drugs safely and to good effect. As paramedic practice has expanded to incorporate advanced and specialist roles in areas such as resuscitation, air ambulance operations, urban search and rescue and major trauma, the need for a wider range of controlled drugs to achieve adequate analgesia and/or sedation has grown. International evidence demonstrates that appropriately trained and experienced paramedics are capable of incorporating such agents in their routine management of patients. The provision of prescribing rights for controlled drugs would enable paramedics to optimise therapeutic regimes across the lifespan and in a range of clinical scenarios to provide safe, effective and individualised care to patients. **London Ambulance Service NHS Trust**

Yes. Prescribing is a professional activity that should be available to all appropriately registered healthcare professionals where it is demonstrated that a) there is a defined patient need for that skill within that professional group and b) the professional has demonstrated that they have the necessary education, training and competence to prescribe safely and effectively for patient benefit. There is a strong and clear justification for paramedics to be able to prescribe appropriate Controlled Drugs, subject to relevant amendment of The Misuse of Drugs Regulations 2001. Patients requiring such prescriptions are those in acute and chronic pain, which is often severe and may be associated with life-threatening conditions. The quality of care can be significantly enhanced by ensuring appropriate access to the most appropriate medicines, subject always to proper control and governance of the medicines themselves, and ensuring that the practitioner is acting only within their education, training and competence. **Chartered Society of Physiotherapy**

Controlled drugs are an essential part of care for some of the most vulnerable patients, such as those at end of life, and being seen in increasing numbers by paramedics and ambulance services. These patients must have access to the medicines they need, within a safe and governanced framework. **South East Coast Ambulance Service NHS Foundation Trust**

To allow for pain management in major trauma and end of life care (EoLC). In terms of prescribing for patient need, the prescribing of controlled drugs should and must be within the scope of practice for Paramedics. These drugs are needed now in the traditional practice of a Paramedic and reduce the practitioner's ability to respond to patient need. Furthermore, the NHS would experience huge efficiencies in the management of certain conditions, if this list of drugs was made available… **North West Ambulance Service NHS Trust**

Some paramedics have become consultants in hospitals and are trained in sedation. There should be no difference for them prescribing drugs in the community and in hospital. **Doctor**

When working in pre-hospital setting, it would be advantageous to be able to administer appropriate medications, for example in a major trauma, morphine or ketamine, may be of benefit. **Nurse/ Health Visitor**

Paramedics can already give intravenous morphine and oromorph for analgesia, and diazepam for seizures. They are therefore already skilled in the safe use and security of controlled drugs. Expanding the number of drugs does not increase the security risk as controlled drugs are already held, but does increase the number of patients who can receive immediate care for their condition, in particular those patients in acute pain, especially palliative patients. **Paramedic**

27% (15) of organisations and 10% (48) of individuals **partly** agreed to paramedics being able to prescribe from the restricted list of controlled drugs. The comments related to suggestions that the list was: too restrictive and needed to be expanded; the need to ensure that other healthcare professionals involved in the patient's care are made aware and wherever possible, included in the decision-making process when prescribing controlled drugs; or that there was a limited need to prescribe controlled drugs.

The range of controlled drugs prescribed may be more sensibly controlled through restricted by judicious application of a formulary rather than by legislation. If a restricted list is to be introduced then drugs such as tramadol might also be considered. Ketamine could be managed through a PGD. **Scottish Directors of Pharmacy**

Paramedics working in advanced roles such as air ambulance, critical care, mountain search and rescue, major trauma, etc. will require access to a wider range of controlled drugs than in the proposed list to achieve adequate analgesia. If a paramedic prescriber was operating within urgent and unscheduled care or a palliative care environment, the proposed list could compromise the level of care that could be delivered to the patient. The proposed list limits treatment options available and may become a barrier to the development of the advanced paramedic role. **South Central Ambulance Service NHS Foundation Trust**

Some of the drugs specified on the list seem at odds with the reasons for extending rights to paramedics, e.g. modified release fentanyl patches for acute breakthrough pain. We felt it probably more consistent with previous decisions on extension of rights to allow prescribing of controlled drugs within their sphere of competence, except for diamorphine, cocaine and dipipanone in the treatment of addiction. **North Cumbria University Hospitals NHS Trust.**

I can only see this being appropriate in very well-defined conditions (mostly palliative care). **Doctor**

I think the list is too restrictive and could limit the effectiveness of advanced paramedics within some areas of practice. **Paramedic**

They should have the same rights as nurse NMP - to treat trauma and cardiac pain. **Nurse/Health Visitor**

11% (6) of organisations and 10% (48) of individuals **disagreed** that paramedics should be able to independently prescribe from the proposed list of controlled drugs. Some of the comments received from respondents stated that the list was too restrictive to benefit patients, whilst others highlighted concerns regarding the ability of paramedics to safely prescribe controlled drugs, making particular reference to insufficient knowledge, skills and training.

No, as the ordering, storage and administration of such medicines has to be tightly controlled, post Shipman. In addition, the security of paramedics and their vehicles would be an issue. However, this may be of benefit in rural areas. **Care Inspectorate**

Concerns over shared documentation with all healthcare professionals to ensure sound judgment to prescribe and issues over supply. **NHS Ayrshire and Arran**

No, but the views of the accountable officers would be important. **Healthcare Improvement Scotland**

At the moment, existing legislation permits all paramedics to administer a limited range of controlled drugs, but the requirements of paramedics working in advanced and specialist roles such as air ambulance, critical care, mountain search and rescue, major trauma, etc. will require access to a wider range of controlled drugs than in the proposed list to achieve adequate analgesia and/or sedation. Also, if a paramedic prescriber was operating within a palliative care environment, a list such as the one proposed could potentially compromise the level of care that could legally be delivered by them to the patient. The proposed list limits treatment options available and may become a barrier to the development of the advanced paramedic role and delivery of care when legislative change is required further down the line.

Therefore, the list is restrictive in its present form and we believe the arrangements for advanced paramedics should be the same as those for other non-medical independent prescribers. Nurse and pharmacist independent prescribers can prescribe any controlled drug listed in schedules 2-5 for any medical condition within their competence, except diamorphine, cocaine and dipipanone for the treatment of addiction (nurse independent prescribers are able to prescribe other controlled drugs for the treatment of addiction). If a few explicit exceptions were stipulated for paramedics, Health Boards/Trusts would still have the opportunity to control which medicines appear within their formulary and what is supplied to advanced paramedics through the Board/Trust. Control of what medicines are prescribable by advanced paramedics through these mechanisms would be a more flexible and future-proofed approach. **UK Ambulance Pharmacists Network**

Use of controlled drugs pre-hospitally should be monitored closely by a patient's own GP who knows the history of a patient's condition. **Prime Care Ambulance Service**

Sources of CD prescriptions should remain minimal and make them not too easy to obtain. Abusers of CDs and other medications may find this an alternative source for abuse in the urgent care setting. **Medway CCG**

Paramedics do not have sufficient training in palliative care, acute pain can be managed using morphine as per existing paramedic exemptions. **Nurse/Health Visitor**

They are already able to administer a limited range of drugs. I do not think they need to be able to prescribe more. **Doctor**

No current requirement. Add these to current paramedic drugs if required. **Paramedic**

4.1.4 Responses to question 4

4) Do you agree with making amendments to medicines legislation to allow paramedics who are independent prescribers to mix medicines prior to administration or direct others to mix?

Response options:

- Yes
- No

89%(50) of organisations and 79% (378) of individuals supported amendments being made to legislation to allow paramedic independent prescribers to mix medicines.

11% (6) of organisations and 20% (96) of individuals did not support the mixing of medicines and 1% (4) of individuals did not provide an answer to this question.

The breakdown (number and percentage) by group can be seen in table 7 below.

	Organisations												Individuals		Other responses *	
	Group 1		Group 2		Group 3		Group 4		Group 5		All Organisations		Group 6			
Option		%		%		%		%		%		%		%		%
Yes	13	87	8	89	9	100	19	86	1	100	50	89	378	79	2	100
No	2	13	1	11	0	0	3	14	0	0	6	11	96	20	0	0
Not answered	0	0	0	0	0	0	0	0	0	0	0	0	4	1	0	0
Total	15	100	9	100	9	100	22	100	1	100	56	100	478	100	2	100

*did not say whether they were responding on behalf of an organisation or as an individual

Table 7: Breakdown by group for responses to question 4

The comments received from organisations and individuals who supported the proposal to allow paramedics to mix medicines made reference to the importance of this aspect of the proposal for meeting patient needs in a timely manner, whilst also ensuring alignment of paramedics with other non-medical prescribers who are able to mix medicines. Additional comments highlighted the importance of mixing taking place only within the paramedics scope of practice and competence.

> *We support the amendment to allow paramedics who are independent prescribers to mix medicines prior to administration or to direct others to mix in order to ensure patients can access treatment without delay.* **Royal Pharmaceutical Society (RPS)**

> *Amendments to legislation has allowed nurse, pharmacist, physiotherapy and podiatry independent prescribers to mix medicines themselves or direct others to mix for an individual patient. The mixing provisions should also extend to paramedic independent prescribers as there are emergency situations where this will be required.* **Scottish Directors of Pharmacy**

We agree with this proposal providing the key points for prescribing and administration of medicines intended to be mixed are followed i.e.

- *Medicines should not be prescribed for mixing unless essential to meet the needs of the patient*
- *Licensed products should be used for preference*
- *If mixing is necessary, the product should, as a preference and where possible, be prepared in a pharmacy. We realise this may not always be practicable for paramedics but in such circumstances they should at least seek the advice of a pharmacist to confirm pharmaceutical compatibility of the products before mixing them, or if there are alternatives to administering mixed medicines for individual patients.*
- *Paramedics should clearly identify which substance(s) should be mixed and in what dosages*
- *Paramedics must ensure that anyone they direct to mix the medicines are competent to do so*. **Guild of Healthcare Pharmacists**

Yes, but explicitly within their level of competence (as through the framework for training to support competency). **Healthcare Improvement Scotland**

Needs to be underpinned by training and understanding scope of practice with locally agreed guidelines. **Pharmacist**

Depending on the mixtures and procedures followed, and the systems in place to ensure that the others are properly trained and supervised. **Doctor**

With correct training, mentoring and governance then there is no reason why this is not acceptable and beneficial to many patients. **Paramedic**

11% (6) of organisations and 20% (96) of individuals did not support the mixing of medicines. The comments received from organisations and individuals who did not support paramedics being able to mix medicines expressed concerns about it being too high risk and the perceived increase in the opportunity for mistakes to be made.

No, there are too many steps/people in the process, which makes it a high risk intervention. **Care Inspectorate**

The lack of practical examples make it difficult to consider. With any examples where use is likely to be limited to a small number of episodes, concern surrounds the frequency of practice for individual paramedic prescribers and their ability to maintain their knowledge base in these situations. In addition, the practical aspects of availability of a range of such drugs and maintain accuracy and infection control whilst mixing are a concern. **Northern Ireland Ambulance Service**

I think this would increase the risk factors in medication errors. **Member of the Public**

I don't agree with directing others to mix the paramedic should be solely responsible for the work and the drugs he deals with. **Paramedic**

Medicines should not be mixed and the task not delegated to others should it be needed. The prescriber takes responsibility. **Nurse /Health Visitor**

4.1.5 Responses to question 5

5) *Do you have any additional information on any aspects not already considered as to why the proposal for independent prescribing SHOULD go forward?*

There were 162 comments in response to this question, the majority emphasising the potential benefits of this proposal. Recurring comments highlighted feelings that independent prescribing by paramedics would lead to: improved patient care, outcomes and experience; a reduction in the number of visits to A&E departments; support the work of GP's in managing increased demand; and enhance the paramedic role.

Other comments expressed that paramedics are highly skilled individuals who provide a high standard of care in a variety of out-of-hospital settings, but are constrained in their practice by not being able to independently prescribe.

We are generally supportive of this going forward as it would be a positive step in delivering safe and efficient healthcare, and could lessen pressure on hospital A&E departments and GP services. **Royal College of Physicians of Edinburgh**

This is a key intervention in the NHS's drive to move care closer to home and limit the reliance on acute trust provision. The profession has reached a suitable level of maturity to ensure this development can be embraced and delivered in a safely controlled and well governed manner. **East Midlands Ambulance Service**

From an educational perspective, this falls in line with what other healthcare professionals are doing. Paramedics are studying alongside nurses, for example, in the field of Advanced Clinical Examination Skills - they are working in our local NHS, often interchangeably with out of hours nursing staff. **Robert Gordon University**

The paramedic profession has evolved considerably during the latter part of the 20th century, and has continued to develop and expand professional and clinical activities. This process of evolution has encompassed very significant developments in pre and post registration education, ensuring that modern day paramedics receive extensive preparation in key areas such as physical assessment, pharmacology, bioscience, and law and ethics. In addition, the development of clinical career pathways incorporating specialist, advanced and consultant levels of practice provides a structure for safe and effective clinical development and provision of support and oversight in clinical practice. The net effect of these changes is that paramedics are now well placed to embrace independent prescribing as a natural evolution of their roles as allied health professionals. **London Ambulance Service**

The clinical arguments for the introduction of independent prescribing, by any registered professional group, are that early intervention achieves better outcomes for the patient. That supports the case for appropriately trained individuals to meet clinical need in their patients at as early stage as possible. Recent experiences of the introduction of independent prescribing by physiotherapists and podiatrists indicate tangible benefits to both patient experience and to service design and provision. We welcome the proposal to extend independent prescribing to paramedics in the hope that the same tangible benefits will be apparent in paramedic care pathways. **Chartered Society of Physiotherapy**

Paramedics work very closely with other primary and urgent care providers, where there is a shortage in one sector, paramedics are often called upon to plug the gaps, having the ability to prescribe appropriate medication, which may not be on a limited PGD or local formulary, would benefit the patient who may currently be forced to wait for treatment, or be transported to A&E… **Nurse/Health Visitor**

Allowing this change could alleviate the need to transfer some patients to hospital, as Paramedics could treat at the scene. This will save time, money and congestion at A&E. **Member of the Public**

For full development of the paramedic profession at advanced level (MSc), paramedics need parity with colleagues from other professions, thereby enabling them to offer bespoke prescribing and so the ability to fully manage those in their care without referral to another point of care where clinically safe and appropriate to do so. This should both improve the patient experience and reduce costs, and therefore be of benefit to the NHS as a whole. **Paramedic**

Great emphasis is placed on the paramedic's duty to avoid admissions to hospital when safe and appropriate to do so. This is often in conjunction with local GP's, community care providers and CCG's. Paramedic prescribing would allow greater avoidance to admission, greater patient experience with the support of the patients GP and practice nurses. **Paramedic**

4.1.6 Responses to question 6

6) *Do you have any additional information on any aspects not already considered as to why the proposal for independent prescribing SHOULD NOT go forward?*

There were 69 comments in response to this question. The comments highlighted the importance of robust clinical governance processes being in place and alignment with other non-medical prescribers. Other comments highlighted the perception that paramedics do not have sufficient patient assessment skills or pharmacological knowledge to safely prescribe medicines. Others felt that independent prescribing by paramedics may lead to further misuse of the ambulance service.

….The safe use of medicines is a national priority within NHS Scotland through our Scottish Patient Safety Programme (SPSP) and other initiatives. The burden of harm in relation to medicines use is significant and this change may contribute further to this. There are insufficiently robust systems in place within the hospital and community setting to monitor any harm associated with these changes or "near misses". **Healthcare Improvement Scotland**

It is absolutely crucial that ambulance services who wish to develop/employ independent prescribers have the necessary support structures in place to ensure robust clinical supervision and governance. All independent prescribers operating within an organisation (ambulance service), must be assigned and have access to suitably qualified medical practitioners. The potential for changes to service user behaviour should not be underestimated. This has previously been observed when changes to the GP contracts were introduced in the early 2000's. As a result, ambulance services experienced as almost immediate increase in call volumes because users chose the fastest response to fulfil their need. There is no doubt that service users will opt for the fastest access to a prescription if given the choice. Importantly, ambulance services should seriously consider whether access to an APP should be directly associated with ringing 999, i.e. should APPs be responding in uniform, in marked up vehicles, to 999 calls at all, because there will inevitably be an association made by service users, between ringing 999 and receiving an immediate prescription **Welsh Therapies Advisory Committee**

The proposal should go forward but a cautious and phased approach is recommended starting with prescribing for specified conditions from a specified formulary. Initially prescribing could be used to support urgent or unscheduled care where there is evidence that specialist paramedics are already making a valuable contribution to patient care and can reduce the need for patients to access other pressured services. **North East Ambulance Service NHS Foundation Trust**

Both scenarios proposed (fall with UTI and chronic LRTI) require antibiotic prescribing which should warrant an actual assessment by a doctor to decide if they are needed and MSU/sputum cultures to guide therapy. Unlike the typical nurse/pharmacist prescriber who deals with asthma/anticoagulation/ wound care/etc. for stable patients, the proposed paramedic prescriber would replace a doctor in an acute clinical setting without anything near the same level of training. **Pharmacist**

Paramedics are not well trained enough to prescribe. **Doctor**

Given the current shortage of paramedics should they be concentrating on providing their "core business" and not taking on work others could be doing **Nurse/Health Visitor**

4.1.7 Responses to question 7

7) *Does the 'Consultation Stage Impact Assessment' give a realistic indication of the likely costs, benefits and risks of the proposal?*

101 comments were received in response to this question.

55% (31) of organisations and 78% (372) of individuals agreed that the Consultation Stage Impact Assessment gave a realistic indication of the likely costs, benefits and risk of the proposal.

- 21% (12) of organisations and 7% (33) of individuals partly agreed.
- 11% (6) of organisations and 13% (62) of individuals disagreed.
- 13% (7) of organisations and 2% (12) of individuals did not answer this question.

The comments from those who **agreed** that the Consultation Stage Impact Assessment gave a realistic indication of the likely costs, benefits and risks of the proposal highlighted a feeling that it was clear, comprehensive and well considered.

The College is in general agreement with the assessment. **Royal College of Physicians of Edinburgh**

Clear and detailed proposal and it appears to have appreciated the relevant issues. **College of Podiatry**

The consultation represents a comprehensive assessment of the likely costs, benefits and risks of the proposal. Key areas relating to 'hidden' costs have been explored, including the likely funding implications relating to the provision of medical mentorship and back-filling practitioners undertaking prescriber training. Risks are well catered for with existing audit and governance arrangements for paramedics and these are amenable to extension to incorporate specific requirements relating to independent prescribing. Commissioning arrangements will be needed to be in place to cover costs of medical supervision although the numbers required would be very small. **Ambulance Lead Paramedic Group**

The consultation stage impact assessment addresses the key considerations likely to be relevant to the implementation of independent prescribing for paramedics. The potential efficiencies, equity gains and improvements in patient outcomes are considered, through reductions in GP appointments and telephone calls to access medicines following consultations, increasing episodes of care with advanced paramedics, timely access to medicines in community settings. It provides a balanced and realistic consideration of likely costs, risks and benefits, whilst also making clear the limitations of current arrangements. It is also consistent with healthcare policy initiatives in enabling workforce redesign and enhancing workforce flexibility. **Faculty of Health Sciences, University of Southampton**

Yes, in addition: The costs to the HCPC in approving paramedic programme needs to be considered. There may be costs for services where a doctor is not part of the service model/provision and whose expertise will be required to be brought in to act as the designated medical Practitioner to provide supervision for the practice-based aspects to the prescribing programmes. **Chartered Society of Physiotherapy**

I believe the main clinical risk is in lack of information sharing. For some bizarre reason, Paramedics working in an NHS Ambulance Service don't have access to a patient's GP records, as the Out of Hours healthcare service do. This is clinically dangerous in terms of seeing, diagnosing and discharging undifferentiated patients. I don't believe that prescribing would make this particularly more dangerous, but it is still the greatest risk to Paramedic Prescribing. **Member of the Public**

Benefits are that with the increase in calls to Ambulance Trusts, the increased pressure on hospitals and the lack of available GP appointments, we need a solution that gives patients the treatment they need at the earliest point this saves time and money across the NHS. **Paramedic**

The consultation is very comprehensive, it covers the primary benefits, risks and challenges. Comparison should be made between the effectiveness of nurse independent prescribers and the potential for other independent prescribers providing adequate training is in place the benefits significantly outweigh the risks, particularly as the risks are controllable through appropriate training and policies, i.e. the proposed practice guidelines. **Paramedic**

The comments from those who **partly agreed**, expressed concerns that the Consultation Stage Impact Assessment did not fully take into account the true cost of training, ongoing mentorship and the potential future cost related to the provision of new drugs being made available to paramedic independent prescribers.

Does not fully explore alternative options to full prescribing from the full formulary. Appears to omit risk of increasing pressure on prescribing paramedic services and potential for paramedics to be seen as "cheap doctors". We also have concerns about the ongoing clinical governance of prescribing. From conversations with representatives of the Department of Health, it appears to be envisaged that advanced paramedics would apply for training in independent prescribing based on their specific role. However once the qualification is achieved this could be used in whatever role they undertake in future, whether NHS or private and regardless of their clinical governance and support structure. With the wide nature of paramedic work, such a role may have a widely different scope of practice than that when they undertook their prescribing training. Medical practitioners can only prescribe without supervision after a prolonged period of undergraduate study and postgraduate training and are all required to revalidate every 5 years. Currently only a small proportion of paramedics are reviewed by the HCPC. We would recommend that consideration is made to regular revalidation of prescribing status - particularly if full prescribing from the full formulary is implemented. **British Association for Immediate Care (BASICS***)*

Not sure financial impact of mentoring and CPD components have been fully realised and it is difficult to have full realisation of the benefits and risks until some level of implementation has occurred. Currently few Trusts employ Advanced Paramedics. In order to benefit from prescribing, those Trusts not currently using an Advanced Paramedic model would need to develop this level of practitioner, which would increase the outlay for each prescriber. Additionally, in order to qualify, Paramedics must be able to work in a mentored practice setting to achieve competence. As Paramedics do not naturally work in such an environment, placements in other settings will be required. This will take them beyond the 26 days identified in the proposal. **North West Ambulance Service NHS Trust**

It is a reasonable document that appears to supply a significant amount of evidence for prescribing but the realities may divert from these assumptions in the fullness of time. **Scottish Ambulance Service**

There appears to be a "culture" within the various ambulance services I've worked with to push paramedics to work at/beyond their boundaries - I am worried about individual practitioner's insight into their own limitations. **Doctor**

Evidence is not provided from experience with implementing prescribing from other professional groups and the actual cost vs the estimated costs. **Nurse/Health Visitor**

Partly, the benefits and risks both for patients and hospitals are fairly clear. However, the extra cost for paying the Paramedics a realistic wage for this would need to be taken into account. **Paramedic**

The comments from those who **disagreed** expressed concerns that the Consultation Stage Impact Assessment did not fully take into account the true cost of training, including the cost of ongoing GP mentorship, and that the overall risk had been underestimated.

Paramedic prescribers would create a cost pressure for the Trust and could lead to an increased demand from patients. Advanced paramedics will need medical mentors to ensure that their practice develops safely and to provide feedback on their prescribing. The currently employed specialist paramedics who provide urgent care services work in isolation but have the support of Patient Group Directions. The main risk is around the definition and sign off of competence for this group of clinicians who see such a wide range of presenting complaints. **South Central Ambulance Service NHS Foundation Trust**

We would anticipate significant additional educational needs for the workforce to attain educational standards to meet the entry criteria and then to achieve paramedic prescriber status. Access to skills and education through higher education institutions would attract associated costs. This would also be the case for maintaining individual practice and provision of clinical supervision before and after achieving prescribing status. In the case of introducing paramedic prescribers to our workforce, NIAS would anticipate additional organisational need to provide educational support and clinical supervision throughout training and education, and medical teams. **Northern Ireland Ambulance Service**

The costs of administration and governance is not considered. **Scottish Directors of Pharmacy**

I think the impact on reduced GP hours is overestimated and the Advanced Paramedic role will simply absorb some of the pressure on primary care without realising any financial benefit. **Yorkshire Ambulance Service**

Failed to consider future rise in demand of the service - once people know the ambulance service prescribe we will be inundated! **Member of the Public**

The benefits are general and not balanced and measured against the risks. **Paramedic**

4.1.8 Responses to question 8

8) *Do you have any comments on the proposed practice guidance for paramedic prescribers?*

There were 116 comments in response to this question. Overall, the comments highlighted that the document offers detailed, thorough and robust guidance in line with other non-medical prescribing professions and is comparable in terms of governance detail and structure.

The document is well written and clearly presented. Greater emphasis should be placed on using the term advanced paramedic practitioner. The use of 'paramedic' in isolation may be misleading and confusing for both paramedics and laypersons. **National Ambulance Service Medical Directors/Association of Ambulance Chief Executives**

The practice guidance document follows the template of other NMP professions practice guidance documents and offers a detailed, thorough and robust guidance from the professional body. It is consistent with the range of practice guidance documents available to other NMP professions, and is comparable in terms of governance, detail and structure. It is appropriate, proportionate and offers adequate safeguards for patients. **Faculty of Health Sciences, University of Southampton**

This guidance appears comprehensive, clear and well written. **British Association for Immediate Care (BASICS)**

They seem very comprehensive, reasoned and well thought out. **Paramedic**

Comprehensive, well thought out document! **Member of the Public**

Looks very sensible and comprehensive. **Doctor**

A small number of comments suggested minor amendments to the *proposed practice guidance for paramedic prescribers.*

> *Security of prescriptions guidance should link directly with that from NHS Protect to enable consistency and updates. The group has some concern over the wording: "normally has 3 years' experience" – felt it should be "has 3 years' experience". There needs to be identified budget streams for prescribing medicines, including access to prescription pads. The practice guidance doesn't appear to make reference to this.* **Health Education North West**

> *Good communication of prescribing decisions to the appropriate professionals is paramount to avoid duplication of prescribing or administration of medicines. Preferably, a record should also be left with the patient or their family at the time to avoid communication problems if the patient later encounters another health professional or service.* **Royal College of Physicians of Edinburgh**

> *Must have undertaken advanced assessment and diagnostic training at level 7. Must have non paramedic governance in place. Must have investment of continued training and development by ambulance services.* **Nurse/Health Visitor**

4.1.9 Responses to question 9

9) *Do you have any comments on the 'Draft Outline Curriculum Framework for Education Programmes to Prepare Paramedics as Independent Prescribers'?*

There were 103 comments in response to this question. The majority of comments highlighted that the Draft Outline Curriculum Framework is comprehensive in its coverage and provides a reasoned and balanced framework for the wider use of prescribing across the specified allied health professionals.

> *We believe the framework is a sound piece of work that will provide a good educational basis to support the proposal.* **College of Paramedics**

> *A useful and informative document which provides a reasoned and balanced rationale for the wider use of supplementary and independent prescribing across the specified allied healthcare professionals. Table 2 provides a very useful reference for practitioners and employers. Supervised practice and clinical supervision are absolutely crucial elements to ensure patient and practitioner safety. The requirement to be working at an advanced level needs to be reinforced. All references to "or equivalent level" should be removed because this term is ambiguous and open to interpretation.* **National Ambulance Service Medical Directors/ Association of Ambulance Chief Executives**

We believe the framework is a sound piece of work that will provide a good educational basis to support the proposal. **The College of Occupational Therapists**

Looks detailed and thorough. **Member of the Public**

Likewise, this seems very comprehensive, reasoned and well thought out. **Paramedic**

Some respondents also highlighted the importance of strict entry requirements to be eligible to undertake a prescribing course and there were a small number of comments suggesting minor amendments to some of the text in the Draft Outline Curriculum Framework.

Education to MSc level initially to ensure capturing right individuals. Mentorship through community based practitioners and BASICs roles. Framework would need to be robustly managed and assured through the professional bodies. Educational standards should also be legislative, i.e. the use of the term Advanced should be a protected title within the NHS, allowing patients and staff to understand the title and the educational standards that are associated with it. Minimum of 3 years post registration experience required in order to become prescriber as the consultation states "normally have three years" should read "must have three years. **North West Ambulance Service NHS Trust**

We do have a general concern about the impact on capacity and availability of medical mentors to support the extension of independent prescribing rights to additional healthcare professions, and the extension of the general pool of non-medical independent prescribers. **North Cumbria University Hospitals NHS Trust**

Many Universities are already delivering the programme, so to integrate Paramedics into this teaching will be achievable. The programmes are robust, safe and effective in producing NMIP. An adaption to the pre-hospital setting to place management into context for the paramedic profession can be added for realism. **St Georges University London**

The criteria for acceptance onto a prescribing course is similar for nurses and paramedics, and requires doctor, employer and financial commitment. This will prevent those without a need for prescribing to commence study. **Paramedic**

Robust formal assessment and peer review are necessary to give patients and public confidence that paramedics are, and continue to be competent to practise. **Member of the Public**

4.1.10 Responses to question 10

10) Do you have any comments on how this proposal may impact either positively or negatively on specific equality characteristics, particularly concerning: disability, ethnicity, gender, sexual orientation, age, religion or belief, and human rights?

There were 119 comments in response to this question. Overall, the comments described the impact of implementing independent prescribing by paramedics as being positive on all groups with protected characteristics, as prescribing would facilitate care closer to home and result in more timely access to appropriate treatment.

> *Paramedic independent prescribing is likely to have a positive impact in all the groups with specific equality characteristics discussed above. Prescribing will facilitate care closer to home, which might be of particular relevance in cases where disability presents particular challenges relating to transfer to other care settings for treatment. Full independent prescribing from the full formulary for any condition would ensure equal access to appropriate prescribing for those groups with the equality characteristics outlined above.* **London Ambulance Service NHS Trust**
>
> *Failure to allow paramedics full prescribing formulary for any condition would potentially discriminate against some patient groups.* **The Royal College of Surgeons of Edinburgh Faculty of Pre Hospital Care - Paramedic Advisory Group**
>
> *The proposal will in the main improve access to medicines and care through paramedics for a range of individuals across the UK.*
> *<u>Positive impact:</u>*
> *On our elderly/frail patients, reducing the need for them to see a GP to gain access to treatment, and it should be quicker. On those with disability/complex communication needs, reducing the need to speak to multiple clinicians would be advantageous*
> *<u>Negative impact:</u>*
> *On obtaining a full history and details of current medication might be challenging unless there was ready access to this through IT systems or similar, as is the case in Scotland. Within the pre-hospital emergency response, in the first instance an advanced paramedic would not have details of any communication needs that perhaps a GP or Health Care Professional working within Primary Care would.* As part of a well governed system an advanced paramedic should have access to communication support for specific patient groups in the same way that a GP would e.g. language line service, British Sign Language/other language interpreters. **UK Ambulance Pharmacists Network**
>
> *I cannot see any obvious negative impacts.* **Healthwatch Bolton**

In essence, this proposal should facilitate timely access to appropriate treatment. It should therefore provide positive benefits to any patient group typically disadvantaged by inequities focused on access to healthcare, whether from disability, ethnicity or age. **Council of Deans of Health**

Some minority groups do not use/seek regular health care from traditional sources/routes but may come into contact with paramedics, who given the right skills and access to independent prescribing, would be able to better interact and provide much needed healthcare/medication to these groups. **Paramedic**

Not allowing highly skilled paramedics to prescribe is discriminatory in that members of other health professional groups are able to. **Doctor**

I believe this will impact positively on disabled people by giving them better access to care closer to home. **Nurse/Health Visitor**

The mobile nature of ambulance and paramedic practice makes healthcare accessible to isolated and/or housebound communities and people. The proposal to allow independent prescribing would be a huge benefit to these groups. **Paramedic**

4.1.11 Responses to question 11

11) Do you have any comments on how this proposal may impact either positively or negatively on any specific groups, e.g. students, travellers, immigrants, children, offenders?

There were 131 comments in response to this question. As in question 10, overall the comments described the impact of implementing independent prescribing by paramedics as being positive on all groups with protected characteristics, as prescribing would facilitate care closer to home and result in more timely access to appropriate treatment. Specific benefits were also highlighted relating to the positive impact on groups such as the homeless, travellers and others who are frequently in differing geographical locations. Other comments expressed the potential challenges of access to medical records for these groups of patients and that there is a risk that such groups may come to depend on paramedics for primary care.

Paramedics are often the only contact these patient groups have with the healthcare system and this would facilitate improved healthcare. **The Royal College of Surgeons of Edinburgh Faculty of Pre Hospital Care - Paramedic Advisory Group**

Paramedics are frequently required to support and care for people who experience illness or injury whilst away from their usual place of residence. This encompasses patients encountered in transport hubs; maritime ports and airports, as well as students living away from home, offenders detained in prison or police custody and immigrant populations. Many of these patient groups may also experience challenges in accessing primary and urgent care services including registration with general practitioners. Due to the nature and accessibility of ambulance service clinicians there is an opportunity to positively impact on normally hard to reach groups, in particular travellers and immigrants who may not have registered access to primary care. Also it will potentially have a positive impact on people with traditionally poor access to healthcare. **National Ambulance Service Medical Directors/ Association of Ambulance Chief Executives**

Positive impact on certain communities, particularly travellers, who are reluctant to seek medical help. **Nurse/Health Visitor**

I cannot see any impact on these specific groups of people, as paramedics treat all of their patients with the same high quality patient care, irrespective of their background. **Member of the Public**

I believe there could be a very real positive impact for groups such as the homeless, travellers and others who are frequently in differing geographical locations. However, there is a very real risk that such groups may depend on paramedics (and the greater ambulance service) for primary care at the expense of the consistency that could be gained by a regular GP. **Paramedic**

Travellers and immigrants who may be more likely to seek help from paramedics in urgent situations will be able to received medication related to palliative care and end of life care more quickly, so this should impact positively on these groups in particular. **Doctor**

Access for these patient's medical records could be challenging which could make them an increased risk demographic. **Paramedic**

5 Next Steps

The results of the public consultation were presented to the Commission on Human Medicines for their consideration in October 2015, with their recommendations published in December 2015. A summary of the CHM recommendations can be accessed here.

The CHM did not support the proposal to introduce independent prescribing by paramedics at this stage, on the grounds that it was felt that paramedics could potentially encounter a very wide range of conditions, and it was not clear if they would have adequate training to assess and diagnose these conditions, and prescribe the appropriate treatment.

The CHM also felt there was lack of clarity as to what constituted an advanced paramedic practitioner and how such a practitioner would be trained in the assessment and diagnosis of the conditions that they may encounter. The CHM therefore felt that at present independent prescribing may represent a risk to patient safety.

NHS England continues to work collaboratively with the CHM, MHRA, DH and the College of Paramedics in taking this proposal forwards. Further updates on progress will be provided in due course.

6 Appendices

6.1 Appendix A: List of organisational responses by group

This appendix contains a detailed breakdown of the responses by group for the first 4 consultation questions only as these questions directly relate to specific aspects of the proposal.

Q1: Should amendments to legislation be made to enable paramedics to prescribe independently?
Yes
No

Group 1: National Organisations and Networks; Professional Bodies and Royal Colleges; Regulators; Government & Arm's Length Bodies

Organisation	Response
BMA - GP Clinical and Prescribing subcommittee	Yes
British Association for Immediate Care	Yes
Care Inspectorate	Yes
Controlled Drugs Accountable Officers' Network Scotland	Yes
Guild of Healthcare Pharmacists	Yes
Health and Care Professions Council	Yes
Healthcare Improvement Scotland	No
National Ambulance Service Medical Directors/Association of Ambulance Chief Executives	Yes
Public Health England	Yes
Royal College of Emergency Medicine	Yes
Royal College of Physicians of Edinburgh	Yes
Royal Pharmaceutical Society	Yes
Scottish Directors of Pharmacy	Yes
The Royal College of Surgeons of Edinburgh Faculty of Pre-Hospital Care - Paramedic Advisory Group	Yes
UK Ambulance Pharmacists Network	Yes

Group 2: Allied Health Professional Organisations, Professional Bodies and Advisory Groups

Organisation	Response
Allied Health Professions Federation	Yes
Ambulance Lead Paramedic Group	Yes
British and Irish Orthoptic Society*	Yes
British Association of Prosthetists and Orthoptists	Yes
Chartered Society of Physiotherapy	Yes
College of Paramedics	Yes
College of Podiatry	Yes
The College of Occupational Therapists	Yes
Welsh Therapies Advisory Committee	Yes

* Following formal correspondence from the British and Irish Orthoptic Society, their response to this question has been amended at their request to “Yes” as they originally provided a “No” response in error.

Group 3: Educational Bodies/Establishments

Organisation	Response
Council of Deans of Health	Yes
Faculty of Health Sciences, University of Southampton	Yes
Health Education Kent Surrey and Sussex	Yes
Health Education North West	Yes
Medway School of Pharmacy	Yes
North West Non-Medical Prescribing Education Group	Yes
Robert Gordon University	Yes
St Georges University London	Yes
University of Cumbria	Yes

Group 4: Commissioning, Commercial and Non-Commercial Organisations; Service Providers; Independent Sector and Trade Associations

Organisation	Response
Dorset NHS CCG	Yes
East Midlands Ambulance Service*	Yes
Eastbourne, Hailsham and Seaford CCG/Hastings and Rother CCG	Yes
Herefordshire CCG	Yes
London Ambulance Service NHS Trust	Yes
Medway CCG	Yes
NEMS CBS Ltd	Yes
NHS Ayrshire and Arran	No
NMPrescribing	Yes
North Cumbria University Hospitals NHS Trust	Yes
North East Ambulance Service NHS Foundation Trust*	Yes
North West Ambulance Service NHS Trust	Yes
Northern Ireland Ambulance Service	Yes
PrimeCare Ambulance Service	Yes
Scottish Ambulance Service	Yes
South Central Ambulance Service NHS Foundation Trust	Yes
South East Coast Ambulance NHS Foundation Trust Inclusion Hub	Yes
South East Coast Ambulance Service NHS Foundation Trust	Yes
Sussex Community NHS Trust	Yes
Welsh Ambulance Services NHS Trust	Yes
West Midlands Ambulance Service NHS Foundation Trust	Yes
Yorkshire Ambulance Service	Yes

* Within Group 4, there were two responses to the consultation on behalf of East Midlands Ambulance Service and two responses to the consultation on behalf of North East Ambulance Service. Formal follow up undertaken by NHS England to seek clarity identified that one response from each organisation came from individuals within those organisations who had accidentally submitted their personal responses to the consultation on behalf of their organisations. At the request of the organisations and individuals involved, the erroneous responses have been removed from this group and the figures amended to show this correction.

Group 5: Patient and Public Representatives; Charitable and Voluntary Associations

Organisation	Response
Healthwatch Bolton	Yes

Q2: Which is your preferred option for the introduction of independent prescribing by paramedics?

Option 1: No change
Option 2: Independent prescribing for any condition from a full formulary
Option 3: Independent prescribing for specified conditions from a specified formulary
Option 4: Independent prescribing for any condition from a specified formulary
Option 5: Independent prescribing for specified conditions from a full formulary

Group 1: National Organisations and Networks; Professional Bodies and Royal Colleges; Regulators; Government & Arm's Length Bodies

Organisation	Response
BMA - GP Clinical and Prescribing subcommittee	Option 2: Independent prescribing for any condition from a full formulary
British Association for Immediate Care	Option 4: Independent prescribing for any condition from a specified formulary
Care Inspectorate	Option 3: Independent prescribing for specified conditions from a specified formulary
Controlled Drugs Accountable Officers' Network Scotland	Option 2: Independent prescribing for any condition from a full formulary
Guild of Healthcare Pharmacists	Option 2: Independent prescribing for any condition from a full formulary
Health and Care Professions Council	Option 2: Independent prescribing for any condition from a full formulary
Healthcare Improvement Scotland	Not Answered
National Ambulance Service Medical Directors/Association of Ambulance Chief Executives	Option 2*: Independent prescribing for any condition from a full formulary
Public Health England	Option 2: Independent prescribing for any condition from a full formulary
Royal College of Emergency Medicine	Option 2: Independent prescribing for any condition from a full formulary
Royal College of Physicians of Edinburgh	Option 4: Independent prescribing for any condition from a specified formulary
Royal Pharmaceutical Society	Option 2: Independent prescribing for any condition from a full formulary
Scottish Directors of Pharmacy	Option 2: Independent prescribing for any condition from a full formulary
The Royal College of Surgeons of Edinburgh Faculty of Pre-Hospital Care - Paramedic Advisory Group	Option 2: Independent prescribing for any condition from a full formulary

UK Ambulance Pharmacists Network	Option 2: Independent prescribing for any condition from a full formulary

*Initially, the National Ambulance Service Medical Directors (NASMeD)/Association of Ambulance Chief Executives (AACE), expressed a preference for Option 3. However, NHS England received a revised position statement from NASMeD/AACE, requesting that their preferred option be changed from Option 3 to Option 2.

Group 2: Allied Health Professional Organisations, Professional Bodies and Advisory Groups

Organisation	Response
Allied Health Professions Federation	Option 2: Independent prescribing for any condition from a full formulary
Ambulance Lead Paramedic Group	Option 2: Independent prescribing for any condition from a full formulary
British and Irish Orthoptic Society	Option 2: Independent prescribing for any condition from a full formulary
British Association of Prosthetists and Orthotists	Option 2: Independent prescribing for any condition from a full formulary
Chartered Society of Physiotherapy	Option 2: Independent prescribing for any condition from a full formulary
College of Paramedics	Option 2: Independent prescribing for any condition from a full formulary
College of Podiatry	Option 2: Independent prescribing for any condition from a full formulary
The College of Occupational Therapists	Option 2: Independent prescribing for any condition from a full formulary
Welsh Therapies Advisory Committee	Option 3: Independent prescribing for specified conditions from a specified formulary

Group 3: Educational Bodies/Establishments

Organisation	Response
Council of Deans of Health	Option 2: Independent prescribing for any condition from a full formulary
Faculty of Health Sciences, University of Southampton	Option 2: Independent prescribing for any condition from a full formulary
Health Education Kent Surrey and Sussex	Option 2: Independent prescribing for any condition from a full formulary
Health Education North West	Option 2: Independent prescribing for any condition from a full formulary
Medway School of Pharmacy	Option 2: Independent prescribing for any condition from a full formulary

North West Non-Medical Prescribing Education Group	Option 2: Independent prescribing for any condition from a full formulary
Robert Gordon University	Option 2: Independent prescribing for any condition from a full formulary
St Georges University London	Option 2: Independent prescribing for any condition from a full formulary
University of Cumbria	Option 2: Independent prescribing for any condition from a full formulary

Group 4: Commissioning, Commercial and Non-Commercial Organisations; Service Providers; Independent Sector and Trade Associations

Organisation	Response
Dorset NHS CCG	Option 2: Independent prescribing for any condition from a full formulary
East Midlands Ambulance Service	Option 2: Independent prescribing for any condition from a full formulary
Eastbourne, Hailsham and Seaford CCG/ Hastings and Rother CCG	Option 2: Independent prescribing for any condition from a full formulary
Herefordshire CCG	Option 2: Independent prescribing for any condition from a full formulary
London Ambulance Service NHS Trust	Option 2: Independent prescribing for any condition from a full formulary
Medway CCG	Option 3: Independent prescribing for specified conditions from a specified formulary
NEMS CBS Ltd	Option 3: Independent prescribing for specified conditions from a specified formulary
NHS Ayrshire and Arran	Option 1: No change
NMPrescribing	Option 2: Independent prescribing for any condition from a full formulary
North Cumbria University Hospitals NHS Trust	Option 2: Independent prescribing for any condition from a full formulary
North East Ambulance Service NHS Foundation Trust	Option 3: Independent prescribing for specified conditions from a specified formulary
North West Ambulance Service NHS Trust	Option 2: Independent prescribing for any condition from a full formulary
Northern Ireland Ambulance Service	Option 3: Independent prescribing for specified conditions from a specified formulary
PrimeCare Ambulance Service	Option 2: Independent prescribing for any condition from a full formulary
Scottish Ambulance Service	Option 2: Independent prescribing for any condition from a full formulary

South Central Ambulance Service NHS Foundation Trust	Option 2: Independent prescribing for any condition from a full formulary
South East Coast Ambulance NHS Foundation Trust Inclusion Hub	Option 2: Independent prescribing for any condition from a full formulary
South East Coast Ambulance Service NHS Foundation Trust	Option 2: Independent prescribing for any condition from a full formulary
Sussex Community NHS Trust	Option 2: Independent prescribing for any condition from a full formulary
Welsh Ambulance Services NHS Trust	Option 3: Independent prescribing for specified conditions from a specified formulary
West Midlands Ambulance Service NHS Foundation Trust	Option 2: Independent prescribing for any condition from a full formulary
Yorkshire Ambulance Service	Option 3: Independent prescribing for specified conditions from a specified formulary

Group 5: Patient and Public Representatives; Charitable and Voluntary Associations

Organisation	Response
Healthwatch Bolton	Option 5: Independent prescribing for specified conditions from a full formulary

Q3: Do you agree that paramedics should be able to prescribe independently from the proposed list of controlled drugs?

Yes
No
Partly

Group 1: National Organisations and Networks; Professional Bodies and Royal Colleges; Regulators; Government & Arm's Length Bodies

Organisation	Response
BMA - GP Clinical and Prescribing subcommittee	Yes
British Association for Immediate Care	Yes
Care Inspectorate	No
Controlled Drugs Accountable Officers' Network Scotland	Partly
Guild of Healthcare Pharmacists	Yes
Health and Care Professions Council	Yes
Healthcare Improvement Scotland	No

National Ambulance Service Medical Directors/Association of Ambulance Chief Executives	Partly
Public Health England	Not Answered
Royal College of Emergency Medicine	Yes
Royal College of Physicians of Edinburgh	Yes
Royal Pharmaceutical Society	Yes
Scottish Directors of Pharmacy	Partly
The Royal College of Surgeons of Edinburgh Faculty of Pre-Hospital Care - Paramedic Advisory Group	Yes
UK Ambulance Pharmacists Network	No

Group 2: Allied Health Professional Organisations, Professional Bodies and Advisory Groups

Organisation	Response
Allied Health Professions Federation	Yes
Ambulance Lead Paramedic Group	Yes
British and Irish Orthoptic Society	Yes
British Association of Prosthetists and Orthoptists	Yes
Chartered Society of Physiotherapy	Yes
College of Paramedics	Yes
College of Podiatry	Yes
The College of Occupational Therapists	Yes
Welsh Therapies Advisory Committee	Partly

Group 3: Educational Bodies/Establishments

Organisation	Response
Council of Deans of Health	Yes
Faculty of Health Sciences, University of Southampton	Yes
Health Education Kent, Surrey and Sussex	Yes
Health Education North West	Yes
Medway School of Pharmacy	Yes
North West Non-Medical Prescribing Education Group	Partly
Robert Gordon University	Yes
St Georges University London	Yes
University of Cumbria	Partly

Group 4: Commissioning, Commercial and Non-Commercial Organisations; Service Providers; Independent Sector and Trade Associations

Organisation	Response
Dorset NHS CCG	Yes
East Midlands Ambulance Service	Yes
Eastbourne, Hailsham and Seaford CCG/Hastings and Rother CCG	Partly
Herefordshire CCG	Yes
London Ambulance Service NHS Trust	Yes
Medway CCG	No
NEMS CBS Ltd	Partly
NHS Ayrshire and Arran	No
NMPrescribing	Yes
North Cumbria University Hospitals NHS Trust	Partly
North East Ambulance Service NHS Foundation Trust	Partly
North West Ambulance Service NHS Trust	Yes
Northern Ireland Ambulance Service	Partly
PrimeCare Ambulance Service	No
Scottish Ambulance Service	Partly
South Central Ambulance Service NHS Foundation Trust	Partly
South East Coast Ambulance NHS Foundation Trust Inclusion Hub	Yes
South East Coast Ambulance Service NHS Foundation Trust	Yes
Sussex Community NHS Trust	Yes
Welsh Ambulance Services NHS Trust	Partly
West Midlands Ambulance Service NHS Foundation Trust	Yes
Yorkshire Ambulance Service	Partly

Group 5: Patient and Public Representatives; Charitable and Voluntary Associations

Organisation	Response
Healthwatch Bolton	Yes

Q4: Should amendments to medicines legislation be made to allow paramedics who are independent prescribers to mix medicines prior to administration and direct others to mix?
Yes
No

Group 1: National Organisations and Networks; Professional Bodies and Royal Colleges; Regulators; Government & Arm's Length Bodies

Organisation	Response
BMA - GP Clinical and Prescribing subcommittee	Yes
British Association for Immediate Care	Yes
Care Inspectorate	No
Controlled Drugs Accountable Officers' Network Scotland	Yes
Guild of Healthcare Pharmacists	Yes
Health and Care Professions Council	Yes
Healthcare Improvement Scotland	Yes
National Ambulance Service Medical Directors/Association of Ambulance Chief Executives	No
Public Health England	Yes
Royal College of Emergency Medicine	Yes
Royal College of Physicians of Edinburgh	Yes
Royal Pharmaceutical Society	Yes
Scottish Directors of Pharmacy	Yes
The Royal College of Surgeons of Edinburgh Faculty of Pre-Hospital Care - Paramedic Advisory Group	Yes
UK Ambulance Pharmacists Network	Yes

Group 2: Allied Health Professional Organisations, Professional Bodies and Advisory Groups

Organisation	Response
Allied Health Professions Federation	Yes
Ambulance Lead Paramedic Group	Yes
British and Irish Orthoptic Society	Yes
British Association of Prosthetists and Orthotists	Yes
Chartered Society of Physiotherapy	Yes
College of Paramedics	Yes
College of Podiatry	Yes
The College of Occupational Therapists	Yes
Welsh Therapies Advisory Committee	No

Group 3: Educational bodies/Establishments

Organisation	Response
Council of Deans of Health	Yes
Faculty of Health Sciences, University of Southampton	Yes
Health Education Kent, Surrey and Sussex	Yes
Health Education North West	Yes
Medway School of Pharmacy	Yes
North West Non-Medical Prescribing Education Group	Yes
Robert Gordon University	Yes
St Georges University London	Yes
University of Cumbria	Yes

Group 4: Commissioning, Commercial and Non-Commercial Organisations; Service Providers; Independent Sector and Trade Associations

Organisation	Response
Dorset NHS CCG	Yes
East Midlands Ambulance Service	Yes
Eastbourne, Hailsham and Seaford CCG/Hastings and Rother CCG	Yes
Herefordshire CCG	Yes
London Ambulance Service NHS Trust	Yes
Medway CCG	Yes
NEMS CBS Ltd	Yes
NHS Ayrshire and Arran	No
NMPrescribing	Yes
North Cumbria University Hospitals NHS Trust	Yes
North East Ambulance Service NHS Foundation Trust	Yes
North West Ambulance Service NHS Trust	Yes
Northern Ireland Ambulance Service	No
PrimeCare Ambulance Service	Yes
Scottish Ambulance Service	Yes
South Central Ambulance Service NHS Foundation Trust	Yes
South East Coast Ambulance NHS Foundation Trust Inclusion Hub	Yes
South East Coast Ambulance Service NHS Foundation Trust	Yes
Sussex Community NHS Trust	Yes
Welsh Ambulance Services NHS Trust	No
West Midlands Ambulance Service NHS Foundation Trust	Yes
Yorkshire Ambulance Service	Yes

Group 5: Patient and Public Representatives; Charitable and Voluntary Associations

Organisation	Response
Healthwatch Bolton	Yes

6.2 Appendix B: Glossary of terms

Allied health professions (AHPs):	Allied Health Professions are a group of professionals who work in health and social care. They prevent disease, diagnose, treat and rehabilitate patients of all ages and all specialities. Together with a range of technical and support staff they deliver patient care, rehabilitation, treatment, diagnostics and health improvement to restore and maintain physical, sensory, psychological, cognitive and social functions. Dietitians, orthoptists, paramedics and radiographers are Allied Health Professionals.
College of Paramedics (CoP):	The College of Paramedics is the recognised professional body for the paramedic and ambulance professions.
Commission on Human Medicines (CHM):	A committee that advises ministers on the safety, efficacy and quality of medicinal products.
Controlled drugs:	Drugs that are listed in the United Kingdom Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2001 which can be prescribed to patients for medicinal purposes, e.g. morphine for pain relief.
Department of Health (DH) England:	The Department of Health England helps people to live better for longer. They lead, shape and fund health and care in England, making sure people have the support, care and treatment they need, with the compassion, respect and dignity they deserve.
Department of Health, Social Services and Public Safety (Northern Ireland):	It is the Department's mission to improve the health and social well-being of the people of Northern Ireland. It endeavours to do so by: •Leading a major programme of cross-government action to improve the health and well-being of the population and reduce health inequalities. This includes interventions involving health promotion and education to encourage people to adopt activities, behaviours and attitudes which lead to better health and well-being. The aim is a population much more engaged in ensuring its own health and well-being. •Ensuring the provision of appropriate health and social care services, both in clinical settings such as hospitals and GPs' surgeries, and in the community through nursing, social work and other professional services.

Exemptions:	Exemptions permit certain listed medicines to be sold, supplied and/or administered to patients by certain health professional groups. Exemptions are distinct from prescribing which requires the involvement of a pharmacist in the sale or supply of the medicine.
Formulary:	The medicines formulary is a list of approved medicines. It is used alongside other resources to promote safe and appropriate prescribing of medicines for patients.
Health and Care Professions Council (HCPC):	The regulator of 16 different health and care professions including the allied health professions. It maintains a register of health and care professionals and is responsible for setting the standards of training, conduct, and competence for these professionals.
Human Medicines Regulations (2012):	The Human Medicines Regulations (2012) govern the control of medicines for human and veterinary use, which includes the manufacture and supply of medicines.
Independent prescriber:	An independent prescriber is a practitioner responsible and accountable for the assessment of patients with undiagnosed and diagnosed conditions and for decisions about clinical management, including the prescribing of medicines.
The Medicines and Healthcare products Regulatory Agency (MHRA):	The Medicines and Healthcare products Regulatory Agency is responsible for regulating all medicines and medical devices in the UK by ensuring they work and are acceptably safe. The MHRA is an executive agency of the Department of Health.
Mixing of medicines:	The combination of two or more medicinal products together for the purposes of administering them to meet the needs of a particular patient.
Non-medical prescribing (NMP):	NMP is prescribing by specially trained healthcare professionals who are not doctors or dentists. They include nurses, pharmacists, physiotherapists, podiatrists and radiographers. They work within their competence as either an independent or supplementary prescriber.

Paramedic:	Paramedics respond to 999 and 111 calls and also work in a variety of healthcare settings, including walk in centres and GP surgeries. They can carry out all aspects of pre-hospital emergency care, ranging from acute problems such as cardiac arrest and major trauma to urgent problems such as minor illnesses.
Patient Group Direction (PGD):	A written instruction for the supply and/or administration of a licensed medicine (or medicines) in an identified clinical situation, where the patient may not be individually identified before presenting for treatment. Each PGD must be signed by both a doctor and pharmacist, and approved by the organisation in which it is to be used.
Patient Specific Direction (PSD):	A prescribers (usually written) instruction for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis.
Scottish Government Health and Social Care Directorate:	The Scottish Government Health and Social Care Directorate aims to help people sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to healthcare. The Directorate also allocates resources and sets the strategic direction for NHS Scotland, and is responsible for the development and implementation of health and social care policy.
Supplementary prescribing:	A voluntary prescribing partnership between the independent prescriber and the supplementary prescriber, to implement an agreed patient-specific clinical management plan with the patient's agreement.
Welsh Department of Health and Social Services:	Is the devolved Government for Wales - working to help improve the lives of people in Wales and make the nation a better place in which to live and work. The aim is to promote, protect and improve the health and well-being of everyone in Wales by delivering high quality health and social care services, including funding NHS Wales and setting a strategic framework for adult and children's social care services. Where there are inequalities in health, work takes place across Government to tackle the social, economic and environmental influences that affect health and well-being.