



# **CONSULTATION ON PROPOSALS TO INTRODUCE INDEPENDENT PRESCRIBING BY PHYSIOTHERAPISTS**

*Developed in partnership with the Medicines  
and Healthcare products Regulatory Agency*

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	Social Care / Partnership Working

**Document Purpose** Consultation/Discussion

**Gateway Reference** 16305

**Title** Consultation on proposals to introduce independent prescribing by physiotherapists

**Author** DH/CNO/AHP

**Publication Date** 15 September 2011

**Target Audience** PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, PCT Chairs, NHS Trust Board Chairs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads

**Circulation List**

**Description** This consultation (15th September – 8th December 2011) concerns proposals for physiotherapists to become independent prescribers of medicines. The responses to the consultation will inform a paper to the Commission on Human Medicines regarding taking the proposals forward. The consultation summary report will be published spring 2012.

**Cross Ref** Allied health professions prescribing and medicines supply mechanisms scoping project report - July 2009

**Superseded Docs**

**Action Required** Responses to consultation

**Timing** **8th December 2011**

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**For Recipient's Use**

# CONSULTATION ON PROPOSALS TO INTRODUCE INDEPENDENT PRESCRIBING BY PHYSIOTHERAPISTS

*Developed in partnership with the Medicines and  
Healthcare products Regulatory Agency*

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First published September 2011

Published to DH website, in electronic PDF format only.

<http://www.dh.gov.uk/publications>

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# Executive Summary

This consultation (15<sup>th</sup> September – 8<sup>th</sup> December 2011) concerns proposals for physiotherapists to become independent prescribers of medicines. It also proposes that physiotherapist independent prescribers are allowed to mix licensed medicines prior to administration and direct others to mix, and to be able to prescribe independently from a limited list of controlled drugs. This would be achieved primarily by changes to the Medicines Act 1968 and the Misuse of Drugs Regulations 2001.

Independent prescribing is defined as: Independent prescribing by an appropriate practitioner (e.g. doctor, dentist, nurse or pharmacist) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing medicines.

An Allied Health Professions (AHPs) Prescribing and Medicines Supply Mechanisms Scoping Project was undertaken in 2009 to establish whether there was evidence of service and patient need to support extending prescribing and medicines supply mechanisms available to AHPs. The project found a strong case for extending independent prescribing to physiotherapists and podiatrists and a project was established to take the work forward.

The development of independent prescribing by physiotherapists is part of a drive to make better use of their skills and to make it easier for patients to get access to the medicines that they need. Independent prescribing can enable new roles and new ways of working to improve quality of services – delivering safe, effective services focussed on the patient experience. It facilitates partnership working across professional and organisational boundaries within commissioning/provider landscapes and with patients to redesign care pathways that are cost-effective and sustainable, e.g. improving the transition from acute to community care. It can enhance choice and competition, maximising the benefits for patients and the taxpayer.

Following recommendation of the Medicines and Healthcare products Regulatory Agency (MHRA) an engagement exercise was undertaken in autumn 2010. The engagement exercise for physiotherapists gathered information on the key issues in respect of independent prescribing by physiotherapists from a range of key stakeholders including; professional bodies, Royal Colleges, individual practitioners and the public.

The response to the two engagement exercises was overwhelmingly positive. 388 responses were received in total – 83% from individuals and 17% from organisations. 91% supported independent prescribing by physiotherapists and podiatrists, 2% were in favour of no change with the remaining 7% undecided or not selecting a preference.

## Independent Prescribing by Physiotherapists Consultation

The responses suggested that a public consultation would be an opportunity to provide clarification on queries raised by respondents to the engagement exercises, particularly on the content of the education programmes and the governance frameworks across regulatory, professional and prescribing bodies. The full report is included in appendix J.

A number of supporting documents are provided alongside the consultation to inform consideration of the options and questions; these include Practice Guidance: Good Prescribing and Medicines Management for Physiotherapists (appendix I) prepared by the Chartered Society of Physiotherapy, Outline Curriculum Independent/Supplementary Prescribing Education Programmes and Outline Curriculum – Conversion Programme from Supplementary to Independent Prescribing (appendix G & H) and impact assessments (appendix C & D).

There are a range of options for the introduction of independent prescribing:

**Option 1. Independent prescribing for any condition from a full formulary**

**Option 2. Independent prescribing for specified conditions from a specified formulary**

**Option 3. Independent prescribing for any condition from a specified formulary**

**Option 4. Independent prescribing for specified conditions from a full formulary**

**Option 5. No change**

The consultations seek answers to the following questions:

Question 1. Which is your preferred option for introducing independent prescribing by physiotherapists

Question 2. Do you agree physiotherapists should be able to prescribe a restricted list of Controlled Drugs (listed in the appendix) with appropriate governance subject to separate amendment of appropriate Regulations?

Question 3. Do you agree with making amendments to medicines legislation to allow physiotherapists who are independent prescribers to mix medicines prior to administration or direct others to mix?

Question 4. Do you have any additional information on any aspects NOT already considered that could prevent the proposal for independent prescribing going forward?

Question 5. Do you have any additional information on any aspects NOT already considered that could support the proposal for independent prescribing going forward?

Question 6. Does the consultation draft Impact Assessment document give an accurate indication of the likely costs and benefits of the proposal?

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- Question 7. Can you offer any additional information to the consultation stage Equality Analysis document on how these proposals 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 8. Can you offer any additional information on how these proposals may impact either positively or negatively on any specific groups e.g. students, travellers, immigrants, children, offenders?

Following the close of the consultation, responses received for this consultation will be collated and analysed. A full government response of the findings; including the preferred option for introducing independent prescribing by physiotherapists and the accompanying comments will be produced and made available before or alongside any further action, and will be placed on the Consultations website by Spring of 2012.

The consultation report will inform a paper by MHRA to the Commission on Human Medicines (CHM) asking them to consider the proposals in the light of the comments received. CHM's will then advise Ministers of their recommendations in relation to independent prescribing by physiotherapists.

# Purpose of the Document

## Introduction to the Consultation

This consultation is in accordance with section 129(6) of the Medicines Act 1968 concerning proposals to enable registered physiotherapists to become independent prescribers. This would be achieved primarily by amendment to the Prescription Only Medicines (Human Use) Order 1997 (the “POM” Order) and consequential amendments to NHS regulations, and Rules made by the Health Professions Council. We are also proposing that physiotherapist independent prescribers are allowed to mix licensed medicines prior to administration and direct others to mix, and to be able to prescribe independently from a limited list of controlled drugs. This would be achieved by changes to the Medicines Act 1968 and the Misuse of Drugs Regulations 2001.

Independent prescribing is defined as: Independent prescribing by an appropriate practitioner (e.g. doctor, dentist, nurse or pharmacist) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing medicines.

This consultation document has been jointly produced by the Department of Health and the Medicines and Healthcare products Regulatory Agency (MHRA) for consultation in England.

## Application to England, Wales, Scotland and Northern Ireland

The proposed changes to medicines legislation would apply throughout the United Kingdom both in the NHS and in the independent and voluntary sectors. This consultation seeks views on amending NHS regulations to extend independent prescribing to physiotherapists working in the NHS in England. The extension of independent prescribing by physiotherapists working within the NHS in Wales, Scotland and Northern Ireland are matters for each of the devolved administrations.

## The Professional Body

The Chartered Society of Physiotherapy is the professional body representing physiotherapists and physiotherapy support workers in the United Kingdom. The role is summarised in Appendix A for information.

## Who can respond to this consultation?

Everyone is welcome to respond. We hope to hear from the public, patients/patient representative groups, carers, voluntary organisations, healthcare providers, commissioners, doctors, pharmacists, allied health professionals, nurses, regulators, non-medical prescribers, the Royal Colleges and other representative bodies.

## Independent Prescribing by Physiotherapists Consultation

The consultation;

**Opens Thursday 15<sup>th</sup> September 2011**

**Closes Thursday 8<sup>th</sup> December 2011**

The consultation process and guidance can be viewed from page 28. The consultation reply form is attached as a separate document (appendix B).

# Introduction to Physiotherapy

## General Information

Physiotherapists are statutorily registered health professionals who diagnose and treat disorders of movement, function, and human performance caused by activity, injury, disease, disability or ageing, particularly those that affect the muscles, bones, joints, nervous system, heart, circulation and lungs. They identify and maximise movement and function through health promotion, preventative healthcare, treatment and rehabilitation using a variety of physical, electro-physical, cognitive and pharmaceutical modalities.

Following pre-registration training, many physiotherapists gain experience within a number of specialties in their early career. Most physiotherapists then go on to specialise, or work exclusively with a specific client group. Physiotherapists work with both adults and children. The most well known fields of specialism include musculoskeletal (such as back pain), sports injuries, neurological rehabilitation (such as stroke, brain injury and neurological disease) and trauma rehabilitation (such as recovery from multiple injuries sustained in accidents). Respiratory and cardiovascular disease are other areas in which large numbers of physiotherapists specialise. Less well-known areas in which physiotherapists specialise include women's health, mental healthcare, learning disabilities, spinal injuries, occupational health and military rehabilitation.

Advanced practice and consultant physiotherapist roles have led the development of physiotherapy to increasing levels of responsibility for a wider range of diagnosis, onward referral and provision of specialist interventions. The public increasingly use NHS and independent sector physiotherapists directly (e.g. via self-referral) for diagnosis and treatment, without contacting a doctor. The physiotherapist will keep the GP informed of treatment given even if the patient has not been referred via a doctor.

Since the advent of modern medicines legislation in 1968, physiotherapists have been using medicines safely in their professional practice via a number of different frameworks. The role of medicines in physiotherapy practice has developed in recent years. The use of injection-therapy in physiotherapy became part of accepted practice during the early 1990's. Physiotherapists use injection therapy in a variety of musculoskeletal and neurological settings to treat pain, inflammations and dystonias (impairment of muscle tone). There are estimated to be around 3000 trained injection-therapy physiotherapists and the standard of training required is defined by the Chartered Society of Physiotherapy (CSP)<sup>1</sup>. Physiotherapists also administer medicines in some settings using Patient Group Directions (PGDs). The first physiotherapist Supplementary Prescribers qualified in 2005.

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<sup>1</sup> CSP Publication *PD071 – CSP expectations of educational programmes in injection-therapy for physiotherapists*, CSP, London 2011 <http://www.csp.org.uk/>

Currently, Patient Specific Directions (PSDs) and Patient Group Directions for supply and administration of medicines, and supplementary prescribing are used in a broad range of healthcare settings. Physiotherapists use these mechanisms with a range of relevant medicines in clinical areas spanning musculoskeletal, pain management, neurological, respiratory, emergency care, women's health and care of older people.

### Examples of Physiotherapy Roles

#### **Musculoskeletal conditions**

An NHS Consultant Physiotherapist for example, will often lead a multidisciplinary team of health professionals in the management of non-surgical musculoskeletal problems, such as back pain and osteoarthritic conditions. They request and interpret investigations such as X-Ray, MRI scans and blood tests, make diagnoses and deliver appropriate management including medicines management.

#### **Respiratory physiotherapy**

Respiratory physiotherapists work across a range of settings managing disorders of the heart and lungs caused by either trauma or chronic disease conditions which in turn will affect a person's ability to move and function to their best ability. Respiratory physiotherapists use a range of medicines to support optimum lung function including oxygen, bronchodilators, antibiotics and pain relief.

Respiratory physiotherapists manage and deliver hospital and domiciliary services for the management of long term conditions such as asthma, chronic obstructive pulmonary disease and cystic fibrosis. They also provide acute management for exacerbations of respiratory disease, manage ventilated patients who may have suffered trauma to the lungs and provide palliative care to those receiving end-of-life care for chronic respiratory disease.

#### **Women's health**

Physiotherapists provide management for conditions such as stress urinary incontinence, overactive bladder symptoms, constipation, other urinary tract and bowel disorders, and specialist post-natal care for women experiencing pelvic pain and dysfunction. Many standardised care pathways advocate primary management with medicines alongside conservative interventions. Women's health physiotherapists work in hospital and community settings, some within self-referral and direct access pathways.

#### **Sports physiotherapy**

Physiotherapists with a specialist interest in sports physiotherapy working in the NHS are based in a range of locations including; hospitals, GP surgeries and sports clubs. Referral to NHS sports physiotherapy services for the treatment of sports injuries can be made through self referral GP or local hospital, depending on local arrangements treating a range of conditions including; sports related musculoskeletal conditions including sports injuries, tendon and muscle sprains and strains, joint pain and arthritis.

For many athletics, rugby and football clubs, a physiotherapist will be the main health professional in regular and prolonged contact with athletes and players. The majority of sports physiotherapists will either be employed by sporting federations, or will work in a self-employed capacity providing direct access routes to physiotherapy care for athletes. The physiotherapist will provide immediate pitch side care such as wound management and suturing, immediate injury care and ongoing rehabilitation for a variety of conditions, in collaboration with a player's GP and/or sporting federation doctors as needed. The physiotherapist is often the only health professional travelling with the sports team in the UK and overseas.

### **Military physiotherapy**

Qualified physiotherapists can apply for Officer selection into the British Army or Royal Air Force and those that are successful become Commissioned Officers. They provide physiotherapy and rehabilitation services for injured military personnel and civilians both in operational and non-operational settings. A commissioned Physiotherapy Officer can be deployed as part of a detachment on operations in either a field-hospital setting or a forward operating base providing immediate life-saving care and rehabilitation to troops. When not deployed, military physiotherapists work in primary care settings such as Primary Care Rehabilitation Facilities (PCRF), Regional Rehabilitation Units (RRU) or Defence Medical Rehabilitation Centres (DMRC). In secondary care, military physiotherapists work in one of several Ministry of Defence Hospital Units (MDHU). There are approximately 125 commissioned physiotherapists in the British Army and Royal Air Force.

The Ministry of Defence also employs approximately 200 civilian qualified physiotherapists who provide services to the British Army, Royal Navy and Royal Air Force at UK and overseas locations.

### **Where Physiotherapists Work**

There are at present over 35,200 physiotherapists registered by the HPC in England and their work spans a wide cross-section of the healthcare system. Most work in the NHS. They work in hospitals and in a wide variety of community teams, GP practices and independent settings. Many physiotherapists provide care for patients and carers in their own homes, in nursing homes or day centres, in schools and in health centres. The Chartered Society of Physiotherapy estimates that around 35% of physiotherapists working in the NHS undertake an element of their work in the private sector. In addition physiotherapists work in other settings such as schools, occupational health, the Armed Forces and with sports teams.

### **How Physiotherapists are Trained and Regulated**

Pre-registration training of physiotherapists consists of an approved three or four-year university degree-level course leading to a BSc in physiotherapy. Students who already hold a BSc in a related science subject can also follow a pre-registration MSc in physiotherapy. Graduates of both the BSc and MSc pre-registration courses are eligible for statutory registration with the regulator – the Health Professions Council (HPC). Registrants are entitled to use the protected title 'physiotherapist'.

## Independent Prescribing by Physiotherapists Consultation

The HPC sets standards for a physiotherapist's education, training, competence, conduct, behaviour and health. Any person who wishes to practise as a physiotherapist in the UK must, by law, have their name registered with the HPC. Physiotherapists must undertake continuing professional development in order to remain registered with the HPC. The HPC also regulates the fitness to practice and re-registration of those already on the register and has the powers to remove individuals from their register if the person falls below the standards required to ensure public safety.

The scope of physiotherapy practice is very wide and covers a variety of physical, cognitive and similar interventions, including medicines use aimed at improving human movement, performance and function. A physiotherapist's scope of practice will change over time because of experience, specialisation in a certain clinical area or with a particular client group, or a movement into roles in management, education or research. A physiotherapist must undertake the necessary ongoing training and experience to demonstrate that they are capable of working lawfully, safely and effectively within their given scope of practice and must not practise in areas where they are not proficient. With regard to prescribing the HPC approve training programmes, sets the standards required of physiotherapist supplementary prescribers and annotates their names on the register.

Current provisions for limited prescribing by physiotherapists require the physiotherapist to obtain an additional annotation to the HPC register to show their prescribing qualification. This regulatory process would also apply to physiotherapist independent prescribers. Appendix E provides further details about independent and supplementary prescribing.

## Current Use of Medicines Supply and Prescribing Mechanisms by Physiotherapists

Physiotherapists currently use medicine via the traditional Patient Specific Direction (PSD), Patient Group Direction (PGD) and Supplementary Prescribing (see appendix E for details). These mechanisms are used in a broad range of community and acute settings. Physiotherapists use these mechanisms with a range of relevant medicines in clinical areas spanning musculoskeletal, pain management, neurological, respiratory, emergency, women's health and care of older people.

## Education Programmes and Continuous Professional Development for Independent Prescribers

The present multiprofessional non-medical prescribing training is provided as an integrated programme for independent and supplementary prescribers. It is the relevant legislative framework which defines the mechanism(s) available to each profession and thus the assessment of course participants. For example nurses and pharmacists, who successfully complete an approved programme are able to practice as both independent and supplementary prescribers. However, physiotherapists who successfully complete an approved programme are only able to practice as supplementary prescribers. Physiotherapists already

## Independent Prescribing by Physiotherapists Consultation

qualified as supplementary prescribers will be required to undertake additional training in order to practice as independent prescribers.

The HPC has already approved a number of education programmes to provide training for physiotherapists as supplementary prescribers. The draft outline curriculum framework for physiotherapist independent and supplementary prescribing is attached at Appendix G. The draft outline curriculum framework for Conversion Programmes to prepare physiotherapist supplementary prescribers as independent prescribers is attached as Appendix H. HPC will have the authority to approve education programmes for the provision of physiotherapist independent prescribing training.

### **Eligibility for Training as a Physiotherapist Independent Prescriber**

Not all physiotherapists would be expected to train to become independent prescribers. The strict eligibility criteria for acceptance on independent prescribing education programmes reflect partnership working between services, commissioners of education programmes and education providers. It is proposed that all entrants to the training programme would need to meet the following requirements:

- Be registered with the Health Professions Council
- Be practising in an environment where there is an identified need for the individual to prescribe independently
- Have at least three years relevant post qualification experience in the clinical area in which they will prescribe
- Have support from their employer
- Have an approved medical practitioner to supervise and assess their clinical training as a prescriber
- Be able to demonstrate how they reflect on their own performance and take responsibility for their own continuing professional development (CPD) including networks for support, reflection and learning.

Physiotherapist independent prescribers would be required to have an annotation on the HPC register. This would require them to undertake appropriate steps to maintain their skills and competence in keeping with the HPC regulatory standards. The HPC would need to amend their standards for physiotherapists, to reflect physiotherapist independent prescribing and they have indicated their willingness to do this in due course if proposals move forward.

### **Continuing Professional Development**

All physiotherapists are required to keep up-to-date in their practice and are required to renew their registration every two years. The HPC sets standards for CPD which all registrants must meet.<sup>2</sup>

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<sup>2</sup> Health Professions Council (2006), *Your guide to our standards for continuing professional development*, HPC, London <http://www.hpc-uk.org>

The HPC undertakes a random sample audit every two years as part of the re-registration process, to ensure that its registrants are meeting its standards for CPD – thus keeping up-to-date and maintaining their fitness to practise. If introduced, physiotherapist independent prescribers would have a similar responsibility to keep up-to-date with clinical and professional developments in medicines use to maintain their registration.

The National Prescribing Centre has developed competency frameworks for non-medical prescribers to be used by clinicians as a source of information and as tools to reflect on practice and identify continuing professional development (CPD) needs.<sup>3</sup> (see [www.npc.co.uk](http://www.npc.co.uk)) The National Prescribing Centre will begin developing a single generic competency framework for all prescribers from July 2011.

### **Current Physiotherapy Supplementary Prescribing CPD<sup>4</sup>**

All physiotherapists have a professional responsibility to keep themselves up-to-date with clinical and professional developments. Supplementary prescribers are expected to keep up-to-date with best practice in the management of the conditions for which they may prescribe. From 2006, physiotherapist supplementary prescribing registrants have been required to meet the Standards for Continuing Professional Development of the HPC. They are required to complete a self-declaration that they have kept up-to-date with practice within their current context and scope of practice. It will be subject to periodic audit, requiring the registrant to submit evidence of their supplementary prescribing CPD to the HPC for scrutiny to support their claim. Employers have a role in partnership with the registrant in enabling access to relevant education and training provision.

### **Governance & Safeguarding**

The role of the HPC is to protect the public. It does this by setting standards for a physiotherapist's conduct, competence, training, character and health. A physiotherapist must be registered with the HPC to practise within the UK and must meet the standards that it sets. The HPC can take action to protect the public where physiotherapists do not meet the necessary standards, including removing them from practice where appropriate. The HPC will set standards for independent prescribing and will also approve the educational programmes which deliver training in independent prescribing to make sure that the programmes meet the necessary standards. A physiotherapist would only be able to act as an independent prescriber if they successfully complete an educational programme and then have their entry on the HPC Register 'annotated' as an independent prescriber. By setting standards, approving programmes and annotating the Register, the HPC can make sure that physiotherapist independent prescribers meet the standards necessary for safe and effective prescribing practice.

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<sup>3</sup> National Prescribing Centre (2010), *Non-medical prescribing by nurses, optometrists, pharmacists, physiotherapists, podiatrists and radiographers, A quick guide for commissioners*, NPC, Liverpool <http://www.npc.nhs.uk>

<sup>4</sup> Department of Health (updated 2005), *Supplementary Prescribing by Nurses, Pharmacists, Chiropodists/Podiatrists, Physiotherapists and Radiographers within the NHS in England*, DH, <http://www.dh.gov.uk/en/index.htm>

All professionals registered with the HPC, including physiotherapists must always practice within their 'scope of practice'. A physiotherapist's scope of practice is the area of practice in which they have the knowledge, skills and experience to practise safely and effectively. This requirement to practice within a physiotherapist's scope of practice would extend to a physiotherapist's prescribing practice. This means that a physiotherapist must only prescribe where they have the appropriate knowledge, skills and experience to do so safely. If they prescribed outside their scope of practice the HPC could take action against them to protect the public.

The HPC's requirements cover physiotherapists working both in the public and private sector. This means that even if a physiotherapist is working in independent practice by themselves, they must still undertake CPD and practice only within their scope of practice.

Physiotherapists working in NHS settings will be governed by the policies and procedures of their NHS employer with regard to medicines governance. Where physiotherapists wish to move into prescribing in private practice they are required to have similar governance policies and procedures in place as described within the practise guidance provided by the The Chartered Society of Physiotherapy (CSP). The CSP is the professional body for the UK's chartered physiotherapists and physiotherapy support workers. It is estimated that over 90% of the UK registered physiotherapists are members of the CSP. The CSP has produced detailed guidance for physiotherapists relating to good practice in medicines use and prescribing. A draft of this guidance is attached to this consultation. (Appendix I).

The National Prescribing Centre will begin developing a single generic competency framework for all prescribers from July 2011. The single competency framework will apply to all existing prescribers and any professions that are granted independent prescribing going forward, including physiotherapists.

Employers will retain responsibility for ensuring adequate skills, safety and appropriate environments for physiotherapist independent prescribing. Employers would also be responsible for ensuring that there is a need for a physiotherapist to undertake prescribing responsibilities, before the physiotherapist embarks on training – as well as ensuring that there is a role to prescribe post-training. The same standards would apply regardless of whether the physiotherapist is working in the NHS, independent or other settings.

### **Access to Medical Records**

In the interest of patient safety, if independent prescribing is implemented it is essential that physiotherapist prescribers ensure they have up-to-date, relevant and proportionate information about a patient's medical history and medicines. Prescribers must assure themselves that they have all relevant information in relation to the individual patient and if there is any doubt, further information should be sought before making a decision whether to prescribe or not to prescribe for the patient.

### Updating the Medical Record

It is essential that any prescribing activity by physiotherapists is known to other healthcare professionals caring for the same patient, such as the patient's GP, and the patient is informed of this. Nurse prescribers and physiotherapist supplementary prescribers are expected to update a patient's notes with their prescribing decisions contemporaneously if possible and in any event within 48 hours of the episode of care. This may be done electronically where possible, via an email or electronic update to the GP's office where the patient's notes are held, or by fax to the GP's surgery, ensuring good information governance procedures are taken to ensure its safe transfer.

### Clinical Governance

Part of the assurance to be put in place for satisfying local clinical governance requirements will be the development of a non-medical prescribing policy that is approved according to local arrangements and frequently monitored and reviewed.

Clinical governance guidance is available from a range of sources but an example is *CPD for Non-Medical Prescribers – A Practical Guide*<sup>5</sup> Appendix 3 'Writing and Maintaining a Non-Medical Prescribing Policy for Your Organisation'.

Examples of non medical prescribing governance in practice can be viewed on the NHS Salford website.<sup>6</sup> Examples can be reviewed relating to strategic planning, risk management, evaluation of clinical governance, medicines management, organisational change (including continuity of responsibilities for non medical prescribing governance) and innovative service redesign using non medical prescribing.

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<sup>5</sup> CPD for non-medical prescribers: A practical guide, p42, Ed Marion Waite & Jan Keenan, 2010, Chichester, Blackwell Publishing

<sup>6</sup> <http://www.salford.nhs.uk/index.aspx>

# Benefits

Evidence of the benefits of non-medical prescribing shows that independent prescribing for nurses and pharmacists has been evaluated as ‘operating safely, prescribing is clinically appropriate, with most trusts having established core clinical governance and management strategies for non-medical prescribing. Evidence indicates that overall patients are satisfied with their experience of nurse and pharmacist prescribing.’<sup>7</sup>

Independent prescribing would improve outcomes for patients, whilst also providing greater cost-effectiveness and choice for patients and commissioners. Physiotherapists would use independent prescribing where autonomy in medicines use would facilitate effective care for the patient, where the timely instigation of appropriate medicines management would prevent a deterioration in a patient’s health status and where the appropriate use of medicines would support good outcomes for the patient from the physiotherapy programme. For example:

Many musculoskeletal services are delivered by physiotherapists and often the total patient pathway may not need the involvement of a doctor. This scenario is increasing with the adoption of self-referral to physiotherapy in the NHS. The care pathways for many musculoskeletal and orthopaedic conditions indicate the use of certain medicines, yet patients may experience a delay in effective pain management if they need to see more than one professional at different times in order to receive the medicines they need to manage their condition. Independent prescribing by physiotherapists would mean that the patient is able to receive all their care, at a single point in time, from one professional where it is appropriate to do so.

Many chronic long-term respiratory conditions are effectively managed in the patient’s own home by a physiotherapist. From time to time, a physiotherapist may assess that a patient’s respiratory function is quickly declining requiring immediate additional new medication to prevent an acute exacerbation (sudden, short but more severe) of a long term condition. Where the physiotherapist is immediately able to prescribe appropriate nebulisers and oxygen, the patient’s condition may be quickly managed, which may reduce the anxiety experienced by the patient and may prevent an unscheduled admission to hospital and the costs associated with this.

<sup>7</sup> Department of health (2011), *Evaluation of nurse and pharmacist independent prescribing*, London, DH

For patients in many clinical settings, adequate pain control is essential to facilitate compliance and progression with exercise and conditioning based rehabilitation programmes. In addition, as rehabilitation programmes progress many patients are able to reduce their need for pain control. Physiotherapists independent prescribers would be able to ensure that the patient's medication needs are tailored to their symptoms and suitable for the stage of physiotherapy-led rehabilitation without delay – avoiding the need for the patient to make an appointment to see their GP or other prescriber.

Independent prescribing would enable innovative service redesign to be planned to make best use of physiotherapists skills in physical movement and rehabilitation, to ensure patients receive the medicines they need at the time they need them. For example, in areas as diverse as women's health and musculoskeletal physiotherapy, enabling patients immediate appropriate pharmacological management alongside physical treatment, whilst avoiding delays associated with additional appointments with other prescribers. Independent prescribing could also provide greater choice for patients, GPs and commissioners. By reducing unnecessary appointments with different professionals, the costs of care may reduce. As specialist physiotherapists draw upon a variety of non-pharmaceutical treatments, it is possible that fewer prescriptions overall would be needed.

Independent prescribing would also enhance the flexibility and expertise of the workforce and thereby improve care for patients now and in the future.

# Approach to the Consultation

## Work to Date

### Scoping Study<sup>8</sup>

An Allied Health Professions (AHPs) Prescribing and Medicines Supply Mechanisms Scoping Project was undertaken in 2009 to establish whether there was evidence of service and patient need to support extending prescribing and medicines supply mechanisms available to AHPs.

The scoping project found that AHPs use prescribing and medicines supply and administration mechanisms safely and effectively to improve patient care in clinical pathways where the application of the mechanisms are suited to the needs of patients.

The project also found that extension of prescribing and medicines supply for certain of the AHPs would improve the patient experience by allowing patients greater access, convenience and choice. The project found a strong case for extending independent prescribing to physiotherapists and podiatrists and a project was established to take the work forward.

Independent prescribing by physiotherapists and podiatrists requires changes to the legislative framework. The Commission on Human Medicines would consider the responses to a public consultation in preparing their recommendations to Ministers in respect of legislative changes.

The development of independent prescribing by a wider range of healthcare professionals is part of a drive to make better use of their skills and to make it easier for patients to get access to the medicines that they need. Independent prescribing is an important part of developing health professionals' roles in delivering frontline care and patient-centred services.

Over time, independent prescribing and supplementary prescribing is also likely to reduce doctors' workloads, freeing up their time to concentrate on patients with more complicated conditions and/or more complex treatments.

Non-medical prescribing supports the achievement of ambitions set out in Equality and Excellence: Liberating the NHS and provides mechanisms to ensure that services can be delivered via new roles and new ways of working: to improve clinical outcomes; empower healthcare professionals to deliver improved clinical outcomes; supports the promotion of health and wellbeing within all clinical interventions; and facilitates partnership working.

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<sup>8</sup> Department of Health (2009). *Allied Health Professions Prescribing and Medicines Supply Mechanisms Scoping Project Report*. London, DH, [www.dh.gov.uk](http://www.dh.gov.uk)

### Engagement Exercise

In July 2009 the Department of Health (DH) Allied Health Professionals Prescribing and Medicines Supply Mechanisms Scoping Project recommended that further work be undertaken to extend independent prescribing to appropriately trained physiotherapists, in order to improve the safety, effectiveness, patient experience and productivity of healthcare. The DH Non Medical Prescribing Board accepted the recommendations and agreed that further work should be undertaken to explore independent prescribing by physiotherapists.

Following recommendation of the Medicines and Healthcare products Regulatory Agency two engagement exercises were held over 12 weeks - 3 September 2010 to 26 November 2010. One was in respect of physiotherapist independent prescribing and the other in respect of podiatrist independent prescribing.

The response to the engagement exercises was overwhelmingly positive. 388 responses were received – 83% from individuals and 17% from organisations. 91% supported independent prescribing by physiotherapists and podiatrists, 2% were in favour of no change with the remaining 7% undecided or not selecting a preference.

There were 177 responses to the engagement exercise in respect of podiatrists, 190 responses in respect of physiotherapists and 21 responses relating to both engagement exercises.

The engagement exercise gathered information on the key issues in respect of independent prescribing by physiotherapists to inform a public consultation.

The responses suggested that a public consultation would be an opportunity to provide clarification on the content of the education programmes and the governance frameworks across regulatory, professional and prescribing bodies.

The analysis of the responses to the engagement exercise is attached at appendix J.

Discussions resulting from the responses to the consultation clarified the specific requirements for physiotherapist independent prescribing. The resulting proposal to take forward independent prescribing includes the mixing of medicines and a limited list of controlled drugs as the most clinically effective, flexible, responsive and safe combination for the delivery of better services for improved patient care and quality of life. The proposal specifically excludes pursuing independent prescribing of unlicensed medicines by physiotherapists due to the limited application outside research, the complexity of governance and patient safety.

# Independent Prescribing by Physiotherapists

Independent prescribing requires a practitioner to be responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing.

Under the Medicines Act 1968, prescribing is restricted to appropriate practitioners. An “appropriate practitioner” is a doctor or dentist within the terms of the legislation covering their prescribing, a nurse, physiotherapist, podiatrist, radiographer and pharmacist supplementary prescriber; nurse or pharmacist independent prescriber and optometrist independent prescriber.

## Non-Medical Independent Prescribing

The original policy objectives for the development of non-medical prescribing from 2000 related to the principles set out in the NHS Plan (DH, 2000): improvements in patient care, choice and access, patient safety, better use of health professionals’ skills and more flexible team working across the NHS. In working towards these objectives the NHS embarked on a graduated move to increase the scope and responsibilities of non-medical prescribing.

## Evidence of the Effectiveness of Non-Medical Independent Prescribing

Over recent years changes to the law have permitted a number of professions, in addition to doctors and dentists, to play an increasing role in prescribing and managing medicines for their patients. There are now over 16,000 qualified nurse independent prescribers and around 1000 qualified pharmacist independent prescribers. More recently, Optometrists have been added to the list of professions able to prescribe independently. Evidence from evaluation of nurse prescribing in 2005 and a recent evaluation of nurse and pharmacist prescribing by the Universities of Southampton and Keele indicates that such prescribing is valued by patients and gives them quicker access to the medicines that they need.<sup>9</sup>

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<sup>9</sup> Department of health (2011), *Evaluation of nurse and pharmacist independent prescribing*, London, DH.  
[www.dh.gov.uk](http://www.dh.gov.uk)

# Proposals

## Options for Introducing Independent Prescribing

There are a range of options for the introduction of independent prescribing by physiotherapists and these are set out in the paragraphs below.

### Option 1. Independent prescribing for any condition from a full formulary

Appropriately trained physiotherapists would be permitted to prescribe independently any medicine for any condition, within their competence.

#### Benefits

Patients would be able to make direct contact with appropriately trained physiotherapists and receive the care and medicines they need, without having to make additional appointments with other prescribers. A greater number of patients could benefit from improved care, faster care and greater convenience. Nurse prescribing changed from a restricted formulary to full formulary independent prescribing and a report of the evaluation of the effectiveness shows that this is the most effective mechanism for safe prescribing.<sup>10</sup>

#### Limitations

This option has no obvious limitations.

### Option 2. Independent prescribing for specified conditions from a specified formulary

Appropriately trained physiotherapists would be permitted to prescribe independently from a list of specified medicines for a specified list of conditions.

#### Benefits

This option could benefit patients provided that their condition and the drugs they need, are listed.

#### Limitations

Patient's whose condition or medicines needs do not appear on the lists of prescribable medicines and conditions, would not be able to benefit. As the physiotherapy profession spans a vast range of patient groups, either the lists of conditions and medicines would need to be extensive, or certain groups of patients would be excluded. In addition, a limited formulary and list of conditions, would need updating regularly, to support ongoing current best practice. This would require lengthy administrative and legislative processes and may not be responsive to the needs of patients or developments in clinical care.

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<sup>10</sup> Department of health (2011), *Evaluation of nurse and pharmacist independent prescribing*, London, DH.  
[www.dh.gov.uk](http://www.dh.gov.uk)

### Option 3. Independent prescribing for any condition from a specified formulary

Appropriately trained physiotherapists would be permitted to prescribe independently for any condition within their competence but only from a list of specified medicines.

#### **Benefits**

A wider range of patients could benefit from this option more than could under option 2.

#### **Limitations**

Patients whose medicines needs do not appear on the list of prescribable medicines would not be able to benefit fully. As with option 2, the lists would quickly become out of date and difficult to administer. This option would be potentially unresponsive to the needs of patients and current best clinical practice. There would also be limitations as described in option 2 concerning updating the list.

### Option 4. Independent prescribing for specified conditions from a full formulary

Appropriately trained physiotherapists would be permitted to prescribe independently any medicine within their competence, but only for specified conditions.

#### **Benefits**

A wider range of patients would benefit from this option, than could benefit under option 2.

#### **Limitations**

Patients with a condition that does not appear on the list, would not be able to benefit fully. As with option 2, the lists would be difficult to administer and keep up-to-date. This option would potentially be unresponsive to the needs of patients and current best clinical practice.

### Option 5. No change

Highly skilled and experienced physiotherapists would continue to be eligible to train as supplementary prescribers. Depending upon local employment arrangements, appropriately trained physiotherapists would continue to supply and/or administer medicines under Patient Group Directions (PGD) and Patient Specific Directions (PSD).

#### **Benefits**

The existing arrangements have proved safe and in some settings, they permit physiotherapists to supply patients with the medicines that they need. Physiotherapist supplementary prescribers will continue to prescribe within a patient-specific clinical management plan.

#### **Limitations**

Recent scoping work<sup>11</sup> has indicated that the existing arrangements do not best support the needs of patients, particularly when a physiotherapist is providing self referral, first contact, diagnostic, or community care. Where patients require medicines management, outside that specified in a Patient Group Direction or Clinical management Plan, they would continue to have to visit another professional. The existing arrangements are difficult and costly to administer.

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<sup>11</sup> Department of Health (2009). *Allied Health Professionals Prescribing and Medicines Supply Mechanisms Scoping Project Report*. [www.dh.gov.uk](http://www.dh.gov.uk)

## Independent Prescribing by Physiotherapists Consultation

Under this option, the creation of innovative new care pathways will continue to be limited, creating less choice and ongoing unnecessary costs for commissioners. Consequently, an opportunity to improve outcomes for patients, would be missed.

### **Question 1. Which is your preferred option for introducing independent prescribing by physiotherapists**

#### Controlled Drugs

Controlled drugs are prescription medicines containing drugs controlled under the Home Office's Misuse of Drugs legislation. Examples include benzodiazepine, morphine and pethidine, but also more commonly used drugs such as diazepam or some codeine preparations, which physiotherapists may need to use to help control a patient's pain. They are classified by law based on their benefit when used in medical treatment and their harm if misused.

Physiotherapists are currently able to prescribe controlled drugs via supplementary prescribing arrangements.

The Chartered Society of Physiotherapy has proposed a restricted list of seven controlled drugs for independent prescribing by physiotherapists namely; Dihydrocodeine (CD for injected route only), Morphine Salt – Oramorph, Fentanyl Patches, Oxycodone Hydrochloride, Temazepam and Lorazepam. The purpose of such medicines is a) pain control in trauma, post-operative pain, chronic pain, oncology (cancer) and end of life physiotherapy services and b) management of respiratory distress in end of life and/or chronic respiratory long term condition physiotherapy services.

Appendix F sets out further information about the proposals for physiotherapist prescribing of controlled drugs. If physiotherapists are to be able to prescribe controlled drugs independently, separate amendments would need to be made to the Misuse of Drug Regulations 2001 and corresponding legislation in Northern Ireland following advice from the Advisory Council on the Misuse of Drugs.

### **Question 2. Do you agree physiotherapists should be able to prescribe a restricted list of Controlled Drugs (listed in appendix F) with appropriate governance subject to separate amendment of appropriate Regulations?**

#### Mixing of Medicines

Clinical practice sometimes requires the mixing of two licensed medicines, for example corticosteroid and local anaesthetic agents in the management of certain musculoskeletal disorders. The mixing of medicines where one is not a vehicle for the administration of the other, creates an unlicensed medicine (i.e. a medicine without a valid UK marketing authorisation). Under medicines legislation the person undertaking the mixing is required to hold a manufacturer's licence. Following amendments to legislation in 2009 nurse and

## Independent Prescribing by Physiotherapists Consultation

pharmacist independent prescribers can mix licensed medicines themselves or direct others to mix for an individual patient. Supplementary prescribers can also mix medicines themselves and direct others to mix where that forms part of the written Clinical Management Plan for an individual patient. **We propose** to extend the mixing provisions to physiotherapist independent prescribers.

**Question 3. Do you agree with making amendments to medicines legislation to allow Physiotherapists who are independent prescribers to mix medicines prior to administration or direct others to mix?**

### Additional information

The following questions invite additional information relevant to these proposals.

**Question 4. Do you have any additional information on any aspects NOT already considered that could prevent the proposal for independent prescribing going forward?**

**Question 5. Do you have any additional information on any aspects NOT already considered that could support the proposal for independent prescribing going forward?**

### Impact Assessment

Impact Assessments are an integral part of the policy making process; the purpose of an IA is to focus on why intervention is necessary, what impact the policy change is likely to have, highlighting costs, benefits and risks. The draft impact assessment (appendix C) contains the available evidence of the actual (where available) and estimated costs and benefits of the introduction of independent prescribing by physiotherapists. The consultation is an opportunity to gather additional evidence to further inform the costs and benefits.

**Question 6. Does the consultation draft Impact Assessment document give an accurate indication of the likely costs and benefits of the proposal?**

### Equality Analysis

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard for the need to:

- Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The Equality Analysis relating to this consultation is a separate attachment (appendix D).

**Question 7. Can you offer any additional information to the consultation stage Equality Analysis document on how these proposals 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 8. Can you offer any additional information on how these proposals may impact either positively or negatively on any specific groups e.g. students, travellers, immigrants, children, offenders?**

## Next Steps

Following the close of the consultation, the Commission on Human Medicines (CHM) will be asked to consider the proposals in the light of the comments received. CHM's advice will be conveyed to Ministers. Subject to the agreement of Ministers, the Medicines and Healthcare products Regulatory Agency (MHRA) will then make the necessary amendments to medicines legislation.

A full government analysis of the outcome of the consultation and the accompanying comments will be made available [before or alongside any further action] and will be placed on the MHRA and DH Consultations websites by Spring 2012.

If the consultation responses support the inclusion of any controlled drugs, the Home Office will ask the Advisory Council on the Misuse of Drugs to consider the proposals and advise Ministers. If Ministerial approval is received, the Home Office will make appropriate amendments to the Misuse of Drugs Regulations 2001.

The Health Professions Council will then begin developing the professional regulations required for the governance of independent prescribing by its members.

The HPC standards will then be subject to a consultation. The development of education programmes and the evaluation of prospective providers would follow, along with the development of education programme curricula.

If all elements of the proposal were approved and all the relevant organisations in a position to complete their elements of the work at the earliest possible point without delay, the first intake of physiotherapists on an independent prescribing education programme would be Autumn 2013.

As there are a number of organisations working within different timeframes contributing to each stage of the process, there is a risk that the optimum timescale for completing the aims of the project may be delayed beyond 2013.

# Consultation Process

## How to Respond

You can respond in one of the following ways:

- By completing the **online consultation** (see link below)
- Download a PDF of the reply form from our website, record your response and email the document to us at [ahpprescribing@dh.gsi.gov.uk](mailto:ahpprescribing@dh.gsi.gov.uk) by Thursday 8th December.
- Alternatively, you may print the reply form, or request a copy to be posted to you. Please send your responses to:  
Sally Brown, Professional Leadership Team  
Department of Health, Quarry House  
Leeds LS2 7UE

If you have any queries or require further information in relation to this consultation please contact Sally Brown, [Sally.Y.Brown@dh.gsi.gov.uk](mailto:Sally.Y.Brown@dh.gsi.gov.uk) or 0113 254 5846.

## Timing and Process

This consultation remains open for 12 weeks and responses should be sent to arrive no later than **Thursday 8th December 2011**.

A proforma is attached at Appendix B, which you may wish to use to submit your reply and which we would find helpful in processing your response. We would very much welcome your views on the issues raised in this document. The proforma also gives details of how to send your response to us.

Following the close of consultation, the Commission on Human Medicines (CHM) will be asked to consider the proposals in the light of comments received. CHM's advice will be conveyed to Ministers. Subject to the agreement of Ministers, we plan to implement changes by Statutory Instrument in summer 2012. Statutory Instruments are available from The Stationery Office (TSO) and via the Office of Public Sector Information (OPSI) website at [http://www.opsi.gov.uk/legislation/about\\_legislation.htm](http://www.opsi.gov.uk/legislation/about_legislation.htm).

## The Consultation Process

### Criteria for Consultation

This consultation follows the 'Government Code of Practice on Consultations'. In particular we aim to:

1. consult at a stage when there is scope to influence the policy outcome
2. consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible
3. ensure the consultation documents are clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals
4. ensure the consultation exercise is accessible to, and clearly targeted at, those people the exercise is intended to reach
5. keep the burden of consultation to a minimum so that consultations are effective and consultees' buy-in is obtained
6. carefully analyse responses and give clear feedback to participants following the consultation
7. provide guidance to officials in how to run an effective consultation and share what they have learned from the experience

The full text of the code of practice is on the Better Regulation website at:

[Link to Government Code of Practice on Consultations](#)

### Comments on the Consultation Process Itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

**Contact:** Consultations Co-ordinator  
Department of Health  
3E48, Quarry House  
Leeds  
LS2 7UE

**e-mail:** [consultations.co-ordinator@dh.gsi.gov.uk](mailto:consultations.co-ordinator@dh.gsi.gov.uk)

**Please do not send consultation responses to this address.**

### Confidentiality of Information

We manage the information you provide in response to this consultation in accordance with the Department of Health's [Information Charter](#).

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

### Summary of the Consultation

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at:

<http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm>

# Appendices

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## Appendix A Role of the Professional Body

The **Chartered Society of Physiotherapy** (CSP) is the professional, educational and trade union body for the UK's 50,000 chartered physiotherapists, physiotherapy students and assistants. The Society aims to:

- lead and support all members in developing and promoting high quality innovative patient care
- protect and further advance the interests and working lives of our members
- raise the profile of the profession and influence the health care agenda
- work openly in partnership to meet the diverse needs of both our members and their patients.

<http://www.csp.org.uk/>

## Appendix E The Mechanisms for the Prescribing, Supply and Administration of Medicines

The mechanisms available for the prescribing, supply and administration of medicines are:

- Patient Specific Directions (PSD)
- Patient Group Directions (PGDs)
- Specific Exemptions covering supply or administration - as contained in medicines legislation applicable to podiatrists, midwives and paramedics
- Supplementary prescribing by nurses, pharmacists optometrists, physiotherapists, radiographers and chiropodists/podiatrists
- Independent Prescribing – doctors, nurses, pharmacists and optometrists only

### **Patient Specific Direction (PSD)**

A Patient Specific Direction is the traditional written instruction, from an independent prescriber, for medicines to be supplied or administered to a named patient. The majority of medicines are still supplied or administered using this process.

All allied health professionals (AHPs) including physiotherapists can supply or administer a medicine under a patient-specific direction.

### **Patient Group Directions (PGDs)**

A Patient Group Direction (PGD) is a written instruction for the supply or administration of a licensed medicine (or medicines) in an identified clinical situation, where the patient may, or may not, be individually identified before presenting for treatment. This should not be interpreted as indicating that the patient must not be identified; patients may or may not be identified, depending on the circumstances.

A PGD is authored by a doctor and a pharmacist and must meet certain legal criteria. Each PGD must be approved by the organisation in which it is to be used, typically a PCT or NHS trust. PGDs can also be developed in specific non-NHS settings such as independent hospitals and clinics registered with the Care Quality Commission and prisons.

PGDs can be used for the supply or administration of medicines by a number of healthcare professions including physiotherapists.

### **Specific Exemptions Covering Supply or Administration**

A number of health professions – for example, midwives, podiatrists, optometrists and paramedics – have specific exemptions in medicines legislation to sell, supply or administer medicines. An exemption allows the relevant health professional to sell or supply the specific medicine listed in the exemption without a prescription. For example, registered podiatrists have exemptions under medicines legislation for parenteral administration of a number of prescription only medicines (POMs), including local analgesias and some painkillers. There are currently NO Exemptions that apply to physiotherapists.

### **Supplementary Prescribing**

Supplementary prescribing was introduced in April 2003 for nurses and pharmacists. It was extended to physiotherapists, podiatrists, radiographers and optometrists in May 2005.

Supplementary prescribing is a voluntary prescribing partnership between the independent prescriber (doctor or dentist) and supplementary prescriber, to implement an agreed patient-specific written clinical management plan (CMP), with the patient's agreement.

Following documentation within the CMP, the supplementary prescriber may prescribe any medicine for the patient that is referred to in the plan, until the next review with the independent prescriber. There is no formulary for supplementary prescribing, and no restrictions on the medical conditions that can be managed under these arrangements. It can be appropriate for example, in the management of long-term conditions.

Supplementary prescribing was introduced in April 2003 for nurses and pharmacists. It was extended to physiotherapists, chiropodists/podiatrists, radiographers and optometrists in May 2005.

### **Independent Prescribing**

Independent prescribing means that the prescriber takes responsibility for the clinical assessment of the patient, establishing a diagnosis and the clinical management required, as well as prescribing where necessary and the appropriateness of any prescription.

From 1 May 2006 Nurse Independent Prescribing (formerly Extended Formulary Nurse Prescribing) was expanded. This allows nurses to prescribe any licensed medicine for any medical condition that a nurse prescriber is competent to treat, including some Controlled Drugs. It allows virtually any licensed medicine in the British National Formulary (see part XVIIIB(ii) of the Drug Tariff) to be prescribed.

Pharmacist Independent Prescribing was also introduced on 1 May 2006 and allows pharmacists to prescribe any licensed medicine for any medical condition that a pharmacist prescriber is competent to treat, this allows access to virtually the whole of the British National Formulary.

Further changes to legislation in 2009 allows nurse and pharmacist independent prescribers to prescribe unlicensed medicines.

## Appendix F List of Controlled Drugs

The prescriptions of controlled drugs:

Preparations which are subject to the prescription requirements of the Misuse of Drugs Regulations 2001 are distinguished in the BNF with the symbol [CD] (controlled drugs). Prescription of Controlled Drugs must be in ink or otherwise indelible and must be signed and dated (computer generated date is not acceptable, but a date stamp is). This must also specify the prescriber's address.

In the prescriber's handwriting:

1. Name and address of patient
2. Preparation strength and form
3. Total quantity (unit in words and numbers)
4. The dose

This does not apply to prescriptions of temazepam (except in certain preparations, see BNF). The prescription is valid for 13 weeks after the date noted on by the prescriber.

The **Chartered Society of Physiotherapy** have proposed the following Controlled Drugs for consideration as part of the Public Consultation for Independent Prescribing.

1. Dihydrocodeine (CD for injected route only)
2. Morphine Salt - Oramorph
3. Fentanyl Patches
4. Oxycodone Hydrochloride
5. Temazepam
6. Lorazepam
7. Diazepam

The purpose of such medicines is a) pain control in trauma, post-operative pain, chronic pain, management of respiratory distress in end of life and/or chronic respiratory long term condition physiotherapy services.

Consideration of any contradictory effects of these drugs would need to be considered, (e.g. In 1 person in 10,000 the drug may have the opposite effect than that intended).

The CSP Guidance relating to Controlled Drugs strongly recommends the use of a Standard Operating Procedure for the management of Controlled Drugs. An example of what should be included is listed below.

- The standard operating procedures must include:
  - Ordering and receipt of CDs
  - Assigning responsibilities
  - Where the CDs are stored
  - Who has access to the CDs
  - Security in the storage and transportation of CDs as required by misuse of drugs legislation

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- Disposal and destruction of CDs
- Who is to be alerted if complications arise
- Record keeping, including:
  - Maintaining relevant CD registers under misuse of drugs legislation
  - Maintaining a record of the CDs specified in Schedule 2 to the Misuse of Drugs Regulations 2001 that have been returned by patients
- The Standard Operating Procedure (SOP) should also include:
  - Responsibilities within the team
  - Validation by healthcare organisation and date
  - Review period, e.g. one, two or three years
  - Lead author and named people contributing to the SOP

## Appendix J Analysis of Responses to the Engagement Exercise

### AHP Medicines Project Physiotherapist and Podiatrist Independent Prescribing Analysis of responses to engagement exercises

Following recommendation of the Medicines and Healthcare products Regulatory Agency two engagement exercises were held over 12 weeks - 3 September 2010 to 26 November 2010. One was in respect of physiotherapist independent prescribing and the other in respect of podiatrist independent prescribing.

Ministers had copies of the engagement exercises as part of the submission (22 July 2009) seeking agreement to the engagement exercises to seek views of patients, the public and partners to inform further work on independent prescribing by physiotherapists and podiatrists.

The response to the engagement exercise was overwhelmingly positive. 388 responses were received – 83% from individuals and 17% from organisations. 91% supported prescribing by physiotherapists and podiatrists, 2% were in favour of no change with the remaining 7% undecided or not selecting a preference.

There were 177 responses to the engagement exercise in respect of podiatrists, 190 responses in respect of physiotherapists and 21 responses relating to both engagement exercises

The same 11 questions were asked in each of the engagement exercises. The responses to each question are summarised below. Background information and the question asked are provided in a box underneath each heading.

#### **Eligibility Criteria for Entry to AHP Independent/Supplementary Prescribing Education Programme**

It is suggested that all entrants to the education programme would need to meet the following requirements:

- Be registered with the Health Professions Council
- Be practising in an environment where there is an identified need for the individual to prescribe independently
- Have at least three years relevant post qualification experience
- Have support from their employer
- Have an approved medical practitioner to supervise and assess their clinical training as a prescriber

**Question – Do you have any comments on these eligibility criteria?**

Just under 60% of responses either made no comment or agreed with the eligibility criteria with many commenting that they were comparable with those required for nurses, pharmacists and optometrists independent/supplementary training programmes which were considered robust.

## Independent Prescribing by Physiotherapists Consultation

The remaining responses made comment on a number of issues that will require further consideration:

- There were suggestions that the eligibility criteria could be strengthened by either extending the period of post qualification experience from three years to five years or three years post qualification in the clinical speciality in which they would prescribe
- A number of podiatrists and physiotherapists already registered as supplementary prescribers proposed exemption from the education programme.
- The potential difficulty for physiotherapists and podiatrists in private practice to prove identifiable need for prescribing
- A number of responses identified difficulty for both NHS and private practitioners in securing a medical practitioner to supervise the learning in practice element of the education programme.

### Options for Independent Prescribing by Physiotherapists and Podiatrists

Option 1: No change  
Option 2: Independent prescribing for specified conditions from a specified formulary  
Option 3: Any condition from a specified formulary  
Option 4: Specified conditions from a full formulary  
Option 5: Any condition from a full formulary  
Option 6: A combination of the above options

**Question 2 – Which of the above options do you believe would safely add the most value to patient care?**

91% supported prescribing by physiotherapists and podiatrists, 2% were in favour of no change with the remaining 7% undecided or not selecting a preference.

The following is a breakdown of the 91% supporting options 2 – 6 demonstrating the significant support for independent prescribing for any condition from a full formulary.

Option 2	7%
Option 3	6%
Option 4	4%
Option 5	72%
Option 6	2%

There were a number of comments made in respect of the specific options supported in the responses. These ranged from the benefits for patients to the training required to ensure competence:

- Independent prescribing has potential to improve the user experience by smoothing the patient pathway through service redesign. For example Diabetes UK responded - *“Appropriately trained podiatrists should be permitted to independently prescribe any medicine for any condition, within their competence. This would enable people with diabetes to have direct contact with podiatrists to receive the care and medicines they need without making additional appointments.*

## Independent Prescribing by Physiotherapists Consultation

- A number of responses supported Option 2 - controlled independent prescribing. The British Medical Association, the Royal College of Surgeons of England and the Royal College of Physicians all expressed this view. RCS stated *“In order to realise some of the patient benefits outlined in the document whilst ensuring patient safety, we would support independent prescribing under specified conditions from a specified formulary (option 2 in discussion document).”*
- In contrast, other responses stressed the importance of flexibility to enable innovative practice and service redesign both now and in the future provided by Option 5.
- The importance of training as an independent prescriber was stressed in a number of responses with a range of perspectives. The BMA stated, *“We believe that a full medical education is necessary to prescribe from the full formulary.”* Others reflected on the potential risks of restricted formularies rather than having robust competence and governance frameworks in place.
- Previous experience of independent non-medical prescribers such as nurses suggested that options other than option 5 would be likely to require frequent revision of conditions and/or formularies to take account of the wide range of clinical specialities in which physiotherapists and podiatrists work.
- The current challenges within health care to make cost savings whilst maintaining and enhancing the quality of care was highlighted in the responses with option 5 supported as the most flexible option to deliver efficient and effective pathways of care.

### **Governance Arrangements for Independent Prescribing by Physiotherapists and Podiatrists**

The engagement exercise explained the role of:

- The Health Professions Council (HPC) is the regulatory body for physiotherapists and podiatrists – setting standards of practise including for independent prescribing and assessing and accrediting recognised education providers of non-medical prescribing training programmes. HPC also requires evidence of continuing professional development for continuing registration including annotation as a non-medical prescriber. The Education and Training Committee has agreed in principle to set standards for independent and supplementary prescribing. HPC will need to consult on those standards for three months prior to consultation.
- The Chartered Society of Physiotherapy (CSP), the Society of Chiropractors and Podiatrists and The Institute of Chiropractors and Podiatrists are the professional bodies for physiotherapists and podiatrists. They will produce detailed guidance for practitioners relating to good practice for independent prescribing.
- Employers who will retain responsibility for ensuring adequate skills, safety and appropriate environments for physiotherapist independent prescribing.
- Responsibility of independent prescriber to ensure they have access to and can update medical records to ensure any prescribing activity is known to other healthcare professionals.

### **Question 3 – Have you any comments on the arrangements outlined for the governance of independent prescribing by physiotherapists/podiatrists if the proposals are taken forward? Are there other factors that should be taken into account?**

The responses to this question focused on the importance of training and competence frameworks, also continuing professional development as an independent prescriber. A number gave examples of local governance arrangements in place for nurse and pharmacist independent prescribers that would apply to physiotherapist and podiatrist independent prescribers.

- There were comments in relation to the usefulness of guidelines from the relevant professional bodies and local guidelines particularly in relation to prescribing of antibiotics. *“I know from discussion with our local specialists in this field that they consider the prescribing of antibiotics to be a very special case because their use impacts on the wider population and not just the individual patient.”*
- Mentorship was suggested during an initial period working as a prescriber.
- The current non-medical prescribing courses that are already in place were recognised as detailed enough to support physiotherapist/podiatrist independent prescribers to apply the new knowledge to their scope of practice.
- A number of responses welcomed the development of a single generic competency framework for all non-medical prescribers that is currently being considered by the National prescribing Centre.
- The BMA questioned the adequacy of current auditing and monitoring of prescribing activities of all allied health professionals. *“We think that it should be possible to audit an individual’s prescribing to ensure that it does not fall outside of the limited formulary allowed by their profession.”*
- A number of suggestions were made in relation to the governance content of training programmes – for example, the importance of information both in respect of access to medical records and in ensuring patients have full information so that they can give full and proper informed consent.

### **Independent Prescribing of Controlled Drugs by Physiotherapists and Podiatrists**

Controlled drugs are prescription medicines containing drugs controlled under the Misuse of Drugs legislation. Examples include benzodiazepine, morphine and pethidine, but also more commonly used drugs such as diazepam or some codeine preparations used to help control a patient’s pain. They are classified by law based on their benefit when used in medical treatment and their harm if misused. Separate amendments would need to be made to legislation governing controlled drugs within the UK by the Home Office and the Department of Health and Personal Social Services in Northern Ireland’s Misuse of Drugs Regulations.

**Question 4 – In what circumstances would it benefit patients if appropriately trained physiotherapists were able to prescribe controlled drugs independently?**

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There were contrasting perspectives in response to this question:

- A number of specific circumstances were identified to support speed of pain relief - for some procedural pain (A&E, fracture clinic, postoperative rehabilitation therapy) and for management of chronic pain conditions and in palliative care.
- The BMA did not believe it would be of benefit for physiotherapists or podiatrists to be able to prescribe controlled drugs.
- The AHP Federation suggested, *“It would be prudent to consider the availability of a limited list of medicines for independent prescriber physiotherapists and podiatrists as is current practice for independent nurse prescribers.”*

### **Mixing of Medicines Prior to Administration by Physiotherapist and Podiatrist Independent Prescribers**

Clinical practice sometimes requires the mixing of two licensed medicines, for example corticosteroid and local anaesthetic agents, in the management of certain musculoskeletal disorders, thus creating an unlicensed medicine.

In May 2010, new guidance on mixing was issued which clarified that:

- Doctors and dentists can mix medicines themselves and direct others to mix
- Nurse and pharmacist independent prescribers can mix medicines themselves and direct others to mix
- Supplementary prescribers can mix medicines themselves, and direct others to mix, but only where that forms part of the written Clinical Management Plan for an individual patient

**Question 5 – In what circumstances would it benefit patient care if appropriately trained physiotherapist/podiatrist independent prescribers were able to mix medicines themselves prior to administration or direct others to do so?**

Three-quarters of responses were positive with musculoskeletal conditions most frequently cited as a specific clinical area in which patients would benefit from physiotherapist and podiatrist independent prescribers being able to mix medicines prior to administration.

- Current guidance restricts best practice.
- Ability of physiotherapist and podiatrist independent prescribers to mix medicines would increase patient comfort, ensure effective treatment and avoid unnecessary delay in treatment.

## Independent Prescribing of Unlicensed Medicines by Physiotherapists and Podiatrists

Unlicensed medicines are those which do not have a Marketing Authorisation (or product licence) which is valid in the UK. The prescribing of unlicensed medicines is permitted under legislation subject to certain conditions which are that the relevant medicinal products are supplied in response to bona fide unsolicited orders, formulated in accordance with the specifications of certain prescribers for use by individual patients on the prescriber's direct personal responsibility, and in order to fulfil "special needs". The product must be made by a person holding a manufacturer's licence for this purpose.

**Question 6 – In what circumstances would it benefit patient care if appropriately trained physiotherapist independent prescribers were able to prescribe unlicensed medicines for their patients?**

The majority of responses expressed caution regarding physiotherapist and podiatrist independent prescribers prescribing unlicensed medicines and suggested restriction to areas of research.

- Unlikely to be within the scope of practice for prescribing by physiotherapists and podiatrists. Would be undertaken by medical specialist or nurse specialist in the first instance.
- *“By and large doctors don't do much of this so why would podiatrists need to?”*

## Prescribing of “Off-Label” Medicines by Physiotherapist/Podiatrist Independent Prescribers

“Off-label” medicines are medicines which have a product licence and a UK marketing authorisation, but are prescribed or supplied for a different use to those detailed in the summary of product characteristics. An example is the use of low dose amitriptyline (an antidepressant) which is also used “off-label” at a low dose for the treatment of neuropathic pain.

**Question 7 – In what circumstances would it benefit patient care if appropriately trained physiotherapists/podiatrists, acting within their level of competence, were able to prescribe medicines “off-label” independently**

Responses to this question mainly focussed on the facility for physiotherapist and podiatrist independent prescribers to be able to prescribe “off-label” medicines specifically for the treatment of neuropathic pain in line with NICE Guidance (2010)<sup>12</sup>.

- Only in exceptional circumstances and likely to be those whose scope of practice includes working in very specialised areas should be able to prescribe “off-label”.
- *“I would support this as long as the medication was part of a recognised national guideline eg. NICE*

<sup>12</sup> NICE Clinical Guideline 96 (2010) Neuropathic Pain - The pharmacological management of neuropathic pain in adults in non-specialist settings, National Institute for Health and Clinical Excellence, London.

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- Cost effectiveness was highlighted particularly in off-label use of amitriptyline – enabling faster access to effective care for patients plus cost and time benefits to GPs and hospital specialists through reduction in duplicated consultations

## Simultaneous Prescribing and Administration by Physiotherapist and Podiatrist Independent Prescribers

### Simultaneous prescribing and administration

For safety reasons, it is a long-standing principle that prescribers prescribe medicines and a pharmacist then supplies the medicines in accordance with the prescription. However, in certain circumstances it may be in a patient's best interests for a prescriber to be able to supply or administer a medicine to that patient immediately, without waiting for a pharmacist to dispense it.

**Question 8 – How would it benefit patients and in what settings, if appropriately trained physiotherapists/podiatrists were able to supply and/or administer medicines that they had prescribed independently?**

The importance of separating prescribing and supply of medicines is recognised in the responses but a number of examples were also provided where patient pathways could be improved by ease of access and provision of timely interventions and care.

- Need to retain the safety check *“Patient safety is paramount and there always needs to be a second check.”*
- Prescribe and Supply within emergency situation or planned care podiatric surgery – for example low molecular weight Heparin for VTE prophylaxis prior to and after surgery.
- In remote rural communities.
- Smoothing the patient pathway – for example speed of treatment for infection or pain management and less patient discomfort due to delay in management, additional appointments and travel.

## Potential Costs and Benefits of Physiotherapist and Podiatrist Independent Prescribing

**Question 9 – Can you offer any information about potential costs and benefits of physiotherapist prescribing for the impact assessment, eg Benefits in terms of time savings to GPs, costs relating to the numbers of physiotherapists likely to go forward for training, or any other factors.**

A recent audit in the North West provided evidence of cost and time savings, which was reinforced by evidence from a range of other responses.

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- In the North West, an audit 288 AHP supplementary prescriber interventions over a four-week period showed that almost half resulted in release of GP time to see other priority patients. In 41 cases (15%), the first point of contact with a podiatrist/physiotherapist prevented a new Medical Consultant appointment and a further 41 follow up appointments. The audit suggested that independent prescribing has the potential to improve these savings even further.
- A number of responses suggested that allowing podiatrists and physiotherapists to prescribe independently would not add additional costs to community medicines budgets but would avoid the need for a patient to visit their GP improving the quality of service and the patient experience.
- Budget arrangements were queried – arrangements need to be in place to ensure physiotherapists and podiatrists have access to the budget required to fund supply.
- Treatment provided locally can reduce visits to hospital and therefore reduce costs to the ambulance service and patients.
- There is potential to avoid hospital admissions via timely and effective control of infection in the foot for patients with diabetes.

### Impact of the Proposals on Equality

**Question 10 – Can you offer any information on how these proposals would impact on equality in your area, particularly concerning disability, ethnicity, gender, sexual orientation, age, religion or belief, and human rights? Could any group be excluded, or better included because of the proposal and will there be any problems or barriers for any minority group?**

Many responses to this question related to culture, language and understanding.

- Lack of understanding by patients of what they need to do and the medicines they need, can be a barrier to receiving effective treatment with a patient failing to visit their GP to get a prescription.
- Some minority groups fail to register with a GP, resulting in a patient being sent to A&E. Physiotherapist and podiatrist independent prescribing would improve access to medicines for these groups.
- *“A busy schedule of appointments seems to overwhelm many patients who are disabled or have mental health problems. I feel that the demand of several repeat appointments to resolve a single health issue has a detrimental effect on adherence to care plans.”*
- *“Independent prescribing would offer improved access to medicines for hard to reach populations such as the elderly in nursing homes, those with mental health issues where attendance at a clinic is difficult.”*

## Other Implications for Implementing Independent Prescribing for Physiotherapists and Podiatrists

### Question 11 – Are there any other implications for implementing independent prescribing for physiotherapists/podiatrists?

Responses to this question focused mainly on the potential independent prescribing by physiotherapists and podiatrists to improve patient care. Other implications identified were training and continuing professional development.

- Bolton Orthopaedic Clinical Assessment and Treatment Service has demonstrated that physiotherapists and podiatrists are making maximum use of non medical prescribing knowledge and skills, with review of medicines taking place in nine out of ten cases and appropriate action taken without the need for the patient to return to the GP
- Training – at Masters level, time and funding to attend, public awareness of level of training were some of the issues raised.
- Evidence-based prescribing essential for safe and effective healthcare.
- Continuing Professional Development (CPD) was highlighted as key to keeping knowledge and skills in prescribing practice up-to-date.
- The BMA supported regular contact between independent prescribing physiotherapists/podiatrists and doctors.

## Conclusion

The engagement exercises have gathered information on the key issues in respect of independent prescribing by physiotherapists and podiatrists to inform a public consultation.

These suggest that the public consultation is an opportunity to provide clarification on the content of the training programmes and the governance frameworks across regulatory, professional and prescribing bodies. The Project Board and working groups set up by the project board have already identified a number of these issues but they will be reviewed in light of the responses to the engagement exercises to ensure they are appropriately addressed within a public consultation.

The responses provide a basis for discussion with the Medicines and Healthcare products Regulatory Agency in relation to feedback on the options presented in the engagement exercise and their advice regarding the range of options for inclusion in a public consultation.

## Appendix K Contributors

### Contributors

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## Independent Prescribing by Physiotherapists Consultation

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Note: \* denotes project board membership, \*\* denotes consultation drafting group membership

## Appendix L Frequently Asked Questions

### **1. What is independent prescribing/non-medical prescribing?**

Over recent years, changes to the law have permitted a number of professions, other than doctors and dentists to play an increasing role in prescribing and managing medicines for their patients without the authority of a doctor or dentist. Non-medical prescribers are professions other than doctors and dentists that have a level of prescribing rights. This includes nurse, pharmacist and optometrist independent prescribing. There are now over 16,000 qualified nurse independent prescribers and around 1,000 qualified pharmacists' independent prescribers.

### **2. Is it safe to allow physiotherapists greater access to prescribing and medicines supply mechanisms?**

Patient safety is of paramount importance. Some physiotherapists already safely use Supplementary Prescribing or supply and/or administer medicine through Patient Group Directions and Patient Specific Directions. Not all physiotherapists would need greater access to medicine for their patients. Only experienced or specialist physiotherapists would meet the pre-requisites for prescribing training.

Increasing access to prescribing and medicines supply mechanisms has the potential to improve patient safety. By reducing delays in care, improving the use of medicines and creating clear lines of professional responsibility, safety risks can be reduced.

### **3. Why extend prescribing and medicines supply for physiotherapists?**

There are many potential benefits for patients, commissioners and providers. The scoping project<sup>13</sup> found that in extending prescribing and medicines supply for physiotherapists, there is potential to improve the quality of care-enhancing patient safety, clinical effectiveness and patient experience. This could be achieved by reducing delays in care, improving compliance in taking medicines, improving patient experience through increasing access, convenience, choice and improving productivity

### **4. What are the current arrangements?**

The arrangements currently in place are complex. Supplementary prescribing training is available to experienced and expert physiotherapists, podiatrists and radiographers. Patient Group Directions for the supply and administration of medicine are available to all Allied Health Professionals, with the exception of art therapists, music therapists and dramatherapists. Exemptions are used by podiatrists and all the professionals can supply and administer medicines under Patient Specific Directions.

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<sup>13</sup> Department of Health (2009). *Allied Health Professionals Prescribing and Medicines Supply Mechanisms Scoping Project Report* DH

### **5. What happens next?**

Following the close of the consultation responses received for this consultation will be collated and analysed. A full government response of the findings; including the options selected for introducing independent prescribing by physiotherapists and the accompanying comments will be produced and made available before or alongside any further action, and will be placed on the Consultations website.

If the public consultation demonstrates support for the introduction of independent prescribing by physiotherapists in the response summary report, the Medicines and Healthcare products Regulatory Agency (MHRA) would then prepare a paper proposing amendments to the Medicines Act 1968 for the Commission on Human Medicines (CHM). CHM will evaluate the responses and make recommendations to ministers.

### **6. Will prescribing costs increase?**

This is not anticipated. There is no general evidence to indicate that prescribing by other professionals, e.g. nurses and pharmacists, has increased prescribing costs. There are some early indications that prescribing by physiotherapists may actually reduce prescribing costs.

### **7. What training will physiotherapists receive?**

Comprehensive and stringent education programmes will be put in place to ensure that physiotherapists are well equipped, confident and educated to independently prescribe medicines. Outline Curricula Frameworks have been developed for the training of independent and supplementary prescribers, and the conversion course from supplementary to independent prescribing (appendix G & H). Non-medical prescribing is targeted at advanced practitioners –not all physiotherapists will want to become, or will meet the entry requirements for training as independent prescribers.

### **8. When will this legislation come into affect?**

There are a number of processes involved when changing legislation in England and a number of government organisations involved in the process. The Department of Health is leading on the public consultation in partnership with the Medicines and Healthcare products Regulatory Agency. They will take forward recommendations to the Commission on Human Medicines and would be responsible to changes in medicines regulations. The Health Professions Council is responsible for amendments to regulations and the registration of independent prescribing practitioners. The Home Office, Drug Regulation Team are responsible for amendments to Controlled Drugs regulations. It is therefore not possible at this stage to give a definitive timeframe for regulations and the subsequent training programmes to be developed, it would however not be earlier than autumn 2013 for the first independent prescribing course places to be taken up by podiatrists. We will however keep people informed of the progress of the project as it develops.

**9. Who can prescribe controlled drugs currently?**

At present, nurse independent prescribers can prescribe from a list of 13 controlled drugs, but only for specified conditions. The Home Office has agreed that pending amendment to the Misuse of Drugs Regulations 2001, nurse and pharmacist independent prescribers will be able to prescribe any licensed controlled drug.

**10. Will physiotherapists in private practice be able to become independent prescribers?**

Yes. Provided they meet the entry requirements of the education programme, including demonstrating they have appropriate governance arrangements in place for their role as an independent prescriber.

**11. Will a physiotherapist working in one clinical area as an independent prescriber be able to independently prescribe if they move to a new clinical area?**

The physiotherapist would need to meet the HPC standards for continued registration which includes that with any move outside current scope of practice the physiotherapist must be certain that they are capable of working safely and effectively including undertaking any necessary training and experience. If the new clinical area requires the physiotherapist to work as an independent prescriber then the organisation and the physiotherapist would need to ensure that all local clinical governance arrangements are in place before the physiotherapist works as a non-medical prescriber.