Department of Health

Engagement exercise

To seek views on possibilities for introducing independent prescribing responsibilities for physiotherapists

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
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Description	This engagement exercise provides background and invites views on possible changes to medicines legislation, which would enable physiotherapists to prescribe independently. It may then inform and assist the development of a formal public consultation by the Medicines and Healthcare products Regulatory Agency (MHRA) proposing amendments to the relevant legislation.
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Timing	**Responses required by 26 Nov 2010**
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For Recipient's Use	

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About this 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.

This engagement exercise provides background information and invites views on the possible changes to medicines legislation, which would enable appropriately trained physiotherapists to prescribe independently. Depending on the outcome of this exercise, and subject to agreement by Ministers, it may then inform and assist the development of a formal public consultation led by the Medicines and Healthcare products Regulatory Agency (MHRA) proposing specific amendments to the relevant legislation.

This engagement exercise will remain open for 12 weeks, ending Friday 26 November 2010.

What is 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. 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[1] and a recent evaluation of nurse and pharmacist prescribing by the Universities of Southampton and Keele (due for publication 2010) indicates that such prescribing is valued by patients and gives them quicker access to the medicines that they need.

1 University of Southampton (2005) Evaluation of extended formulary independent nurse prescribing – Executive Summary, Department of Health, London.

Physiotherapists have been involved in the direct care of patients for many years. Physiotherapists have experience in the treatment of conditions with medicines through Patient Specific Directions[2] and Patient Group Directions[3]. Since 2005, experienced physiotherapists have been able to train as Supplementary Prescribers (Appendix 1 contains further detail about the various non-medical prescribing and medicines supply mechanisms). This engagement exercise seeks views on possibilities for introducing independent prescribing responsibilities for physiotherapists.

Who can respond to this engagement exercise?

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

How to respond

You can respond in one of two ways:

- By using the electronic response form. Type your answers to the questions into the boxes provided. When you have completed the final question (question 11) and entered your details below it, click on 'Save form'. This creates a pdf file which you should save to your computer desktop. You can then email the pdf file to us at **ahpprofessionalleadershipteam@dh.gsi.gov.uk** using the 'Attach to email' option in the 'File' menu of the pdf.
- Alternatively, you may print the form and send it in hard copy to: Shelagh Morris, Professional Leadership Team, Department of Health, Quarry House, Leeds LS2 7UE

If you have any queries or require further information in relation to this engagement exercise please contact Alex Hill, alexandra.hill @dh.gsi.gov.uk or 0113 254 5846.

2 The term "Patient Specific Direction" is not defined in legislation. It refers to the written instruction of a prescriber which enables a person to sell, supply or administer a medicine to a named patient.

3 The term "Patient Group Direction" and the associated legal requirements are defined in medicines legislation.

Confidentiality of Your Response

We manage the information you provide in response to this engagement exercise 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. However, the information you send us may need to be passed on to colleagues within the UK Health Departments.

www.dh.gov.uk/en/FreedomOfInformation/DH_088010

What physiotherapists do

Physiotherapists are statutorily registered health professionals who diagnose and treat disorders of movement, function, physical performance and / or pain caused by activity, disease, disability or ageing, particularly those that affect the muscles, bones, 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 disciplines in their early career. Most physiotherapists then go on to specialise, or work exclusively with a specific client group. Perhaps 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 broken bones). 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, acute trauma, vascular, mental health, learning disabilities, spinal injuries, occupational health and military rehabilitation.

Advanced and consultant physiotherapist roles have led the development of physiotherapy to increasing levels of responsibility for diagnosis, onward referral and provision of specialist interventions. The public increasingly use NHS and independent sector physiotherapists directly (eg self-referral) for diagnosis and treatment, without contacting a doctor.

Since the advent of modern medicines legislation in 1968, some physiotherapists have been using medicines safely in their professional practice via a Patient Specific Direction from a doctor. The role of medicines in physiotherapy practice has developed in recent years. The use of injection-therapy in physiotherapy became accepted practice during the 1980's and 1990's, whereby local anaesthetics and corticosteroids are administered by specialist physiotherapists trained in injection therapy for

the management of some musculoskeletal disorders. There are now estimated to be around 3000 trained injection-therapy physiotherapists. More physiotherapists have administered medicines in practice since the introduction of Patient Group Directions in 2000 and the first physiotherapist Supplementary Prescribers qualified in 2005. Currently, Patient Specific Directions and Patient Group Directions for supply and administration, and supplementary prescribing are used in a broad range of primary care and acute 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, paediatric and elderly care.

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 XRay, MRI scans and blood tests, make diagnoses and deliver treatment including exercises, postural advice, manipulation and medicines. Presently care can be delayed when patients have to make additional visits to other prescribers.

Respiratory physiotherapy

Respiratory physiotherapists work across a range of settings managing disorders of the heart and lungs 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

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 self-referral and direct access routes to 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.

Where physiotherapists work

There are at present over 42,000 physiotherapists registered in UK 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 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 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'. 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 is very wide and covers a variety of physical, cognitive and kindred interventions, including pharmaceutical interventions aimed at improving physical movement 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. The HPC approves the training, sets the standards required of physiotherapist supplementary prescribers and annotates their names on the register.

This regulatory process would also apply to physiotherapist independent prescribers.

How would physiotherapist independent prescribers be trained?

The present multiprofessional training is provided as an integrated programme for independent and supplementary prescribers. It is the legislative framework which defines the mechanism(s) available to each profession and the assessment of course participants. For example nurses and pharmacists,who successfully complete the programme are able to practice as both independent and supplementary prescribers. However, physiotherapists who successfully complete the programme are only able to practice as supplementary prescribers. Appendix 1 provides further details about independent and supplementary prescribing.

The HPC has already approved a number of courses to provide training for physiotherapists as supplementary prescribers. An outline curriculum framework for physiotherapist independent prescribing would need to be developed and the HPC will have the authority to approve courses for the provision of physiotherapist independent prescribing training. Physiotherapists already qualified as supplementary prescribers may be required to undertake additional training in order to practice as independent prescribers.

Eligibility for training as a physiotherapist independent prescriber

Not all physiotherapists would need to train to become independent prescribers. It is suggested 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
- Have support from their employer
- Have an approved medical practitioner to supervise and assess their clinical training as a prescriber

Physiotherapist independent prescribers would have an annotation on the HPC register. This would also 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.

QUESTION

1. Do you have any comments on these eligibility criteria?

What benefits would physiotherapist independent prescribing bring?

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 enhance the aims of the physiotherapy programme that has already been established for the patient. 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. Independent prescribing would mean that the patient is able to receive all their care 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 medication to prevent an acute exacerbation of a chronic condition. Where the physiotherapist is immediately able to prescribe appropriate nebulisers and oxygen, the patient's condition may be quickly managed, which reduces the anxiety experienced by the patient and may prevent an unscheduled admission to hospital.
- 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 with autonomy in medicines use 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.

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 sports physiotherapy, enabling patients immediate appropriate pharmacological management alongside physical treatment, whilst avoiding delays associated with additional appointments with other pescribers. 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.

Protecting the public

Physiotherapist independent prescribing has the potential to improve patient safety by improving medicines management, reducing delays in receiving care and potentially reducing hospital admissions.

Safeguards are of utmost importance because independent prescribing by any profession carries inherent risks. The two main risks which must be considered are:

- the potential risk to patient safety of inappropriate prescribing of medicines; and
- the risk to patient safety of failure to share information e.g. if the GP record was not updated in a timely manner.

The following principles would underpin prescribing responsibilities for physiotherapists:

- Patient safety is paramount. Prescribing responsibilities should only be enabled if they will deliver safe, effective and more convenient care for patients
- Prescribers should only prescribe and practice within the limits of their clinical competence and scope of practice
- Prescribing must be underpinned by robust governance structures

- Independent prescribers must take full clinical and professional responsibility for their decisions. Prescribers need to be able to recognise when they need to ask for support in relation to a patient's care
- Training should be determined locally, within a nationally agreed outline curriculum for prescribing training
- Dispensing pharmacists and those charged with reimbursing prescriptions need to be able to identify prescribers easily through an annotation on the professional register
- As is the case for existing prescribers who independently prescribe, the same standards of training, practice, governance and regulation will apply regardless of whether the physiotherapist is working in the NHS, independent or other settings.

Governance and safeguards

The Health Professions Council (HPC) was created by the Health Professions Order 2001 and is the statutory regulator of 15 health professions, including physiotherapy. As part of their duty to protect the public, the HPC has a statutory responsibility to set standards of proficiency for physiotherapists. This would include setting standards for independent prescribing. The HPC would also have a duty to assess and accredit educational institutions as recognised providers of training for physiotherapist independent prescribing.

The Chartered Society of Physiotherapy (CSP) is the professional body for the UK's chartered physiotherapists. The CSP will produce detailed guidance for practitioners relating to good practice for independent prescribing, if this is introduced. As has been the case for nurses, pharmacists and optometrists, the National Prescribing Centre offered to produce a competence framework for physiotherapist independent prescribers. However, the development of a single generic competency framework for all prescribers is currently being considered.

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 opportunity to prescribe post-training. The same standards would apply regardless of whether the physiotherapist is working in the NHS, independent or other settings.

Continuing Professional Development (CPD):

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. 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.

Access to the medical record:

If independent prescribing is implemented it is essential that prescribing physiotherapists have up-to-date relevant and proportionate information about a patient's medical history and medicines. This is achieved by patient consent, to gain either by direct access to the patients file in secondary care, GP record in primary care or the community and via referral letters in outpatient settings. Individual prescribers must assure themselves that they have all relevant information and if there is any doubt, further information should be sought before prescribing takes place.

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 patients informed of this. Nurse prescribers and existing physiotherapist supplementary prescribers are currently expected to update a patient's notes contemporaneously if possible and in any event within 48 hours of the episode of care. 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. There will be a requirement on prescribing physiotherapists to update the patient's relevant medical records in a timely manner.

Options for introducing physiotherapist independent prescribing

Independent prescribing by physiotherapists could take various forms, such as those outlined in the options below. Appendix 2 outlines the main conditions and medicines pertaining to physiotherapy practice.

Option 1. 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.

Limitations

Recent scoping work[4] 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, they would continue to have to visit another professional. The existing arrangements are difficult and costly to administer.

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.

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.

4 Department of Health (2009). Allied Health Professionals Prescribing and Medicines Supply Mechanisms Scoping Project Report. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103949.pdf

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, 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 be difficult to administer and this option would be potentially unresponsive to the needs of patients and current best clinical practice.

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. 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.

Limitations

This option has no obvious limitations. It is the most flexible option and stands to benefit the most patients.

Option 6. A combination of the above options

Appropriately trained physiotherapists would be able to prescribe independently by some combination of the above options. This could be achieved in a number of ways. For example, prescribing any medicine within the prescriber's competence in a hospital setting, but only from a list of specific medicines in a community setting.

Benefits (based on the example above)

This approach could benefit patients, provided that their condition or the medicine they need was on the list, for the setting in which their care was being delivered.

Limitations (based on the example above)

This approach could be difficult to administer and regulate, particularly for individual physiotherapists who work in a combination of different settings. Patients whose conditions or medicines needs vary from the defined list would not be able to benefit fully. This option would also create a risk that patients moving between settings would be unable to receive consistent care.

QUESTION

2. Which of the above options do you believe would safely add the most value to patient care? (if option 6, please provide details)

3. Have you any comments on the arrangements outlined above for the governance of independent prescribing by physiotherapists if the proposals are taken forward? Are there other factors which should be taken into account?

Further considerations

Controlled drugs

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, 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. If physiotherapists are to be able to prescribe controlled drugs independently as part of any of the above options, 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.

Physiotherapists are currently able to prescribe controlled drugs via supplementary prescribing arrangements. At present, nurse independent prescribers can prescribe from a list of 13 controlled drugs, but only for specified conditions. Pharmacist independent prescribers cannot as yet prescribe any controlled drug independently. Optometrist independent prescribers cannot prescribe controlled drugs. However, changes to UK misuse of drugs regulations are anticipated to enable nurse and pharmacist independent prescribing of controlled drugs, thus removing the present restrictions for nurse and pharmacist independent prescribers.

QUESTION

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

Mixing of medicines prior to administration

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[5] 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 independent prescribers were able to mix medicines themselves prior to administration or direct others to do so?

5 National Prescribing Centre (2010). Mixing of medicines prior to administration in clinical practice: medical and non-medical prescribing. Gateway ref: 14330

Prescribing of unlicensed medicines

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?

"Off-label" prescribing or supply of medicines

These are medicines which have a product licence or 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) in the treatment of neuropathic pain. Presently doctors, dentists, nurse and pharmacist independent prescribers, and allied health profession supplementary prescribers are able to prescribe medicines in this way.

QUESTION

7. In what circumstances would it benefit patient care if appropriately trained physiotherapists, acting within their level of competence, were able to prescribe medicines "off label" independently?

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 that 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. For example, a patient may benefit from the delivery of a corticosteroid injection for arthritis pain, during the course of an outpatient appointment, rather than having to wait for another appointment to have the injection delivered. Physiotherapists are already able to supply a limited range of medicines direct to their patients under Patient Group Directions. In such settings, the supplies of medicines must be stored safely and in accordance with any special conditions relating to specific medicines.

It is not however the intention that physiotherapist independent prescribers should, as a normal routine, supply medicines direct to their patients. The dispensing of prescriptions properly lies with pharmacists. The sale, supply and administration arrangements existing under Patient Group Directions would remain unchanged.

QUESTION

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

Additional questions:

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?

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?

11. Are there any other implications for implementing independent prescribing for physiotherapists?

Name

Patient/Public ☐ AHP ☐ Doctor ☐ Nurse ☐ Pharmacist ☐

Organisation (if applicable)

Are you responding on behalf of the organisation ☐

Email:

Tel No:

Now click on 'Save form' to create a pdf which you can email to us at **ahpprofessionalleadershipteam@dh.gsi.gov.uk** (please refer to page 5 if you need more detailed instructions on how to do this).

SUBMIT by email **Save form**

APPENDIX 1

Non-medical prescribing and medicines supply mechanisms[6]

Mechanism summary
Patient Specific Direction is a prescriber's (normally written) instruction, which enables a person to supply or administer a medicine to a named patient.
Patient Group Direction within the NHS is a written instruction for the supply and/or administration of a licensed medicine to a patient or group of patients, where the patient may not be individually identified before presenting for treatment. The Direction must be agreed/signed by a doctor and a senior pharmacist, and approved by the employer – typically a PCT or NHS Trust. It authorises certain named registered health professional(s) to supply/administer a licensed medicine. **Patient Group Directions** outside the NHS are restricted to independent hospitals, clinics and agencies registered with the Care Quality Commission in England and equivalents in the devolved administrations. They can also be implemented, subject to conditions, by the Defence Medical Services, the UK Police Forces and the UK Prison Services. The Direction enables the sale, supply and/or administration of a licensed medicine to a patient or group of patients, where the patient may not be individually identified before presenting for treatment. The Direction must be agreed/signed by a doctor and a senior pharmacist, and approved by the body or representative specified in medicines legislation. It authorises certain named registered health professional(s) to supply/administer a licensed medicine.
Exemptions (to medicines legislation) allow sale, supply and administration of specific drugs in specific circumstances.

6 Further details can be found in DH and National Prescribing Centre guidance, and an overview with definitions in Medicines Matters (DH, 2006).

Mechanism summary
Supplementary Prescribing is a voluntary prescribing partnership between individual members of certain registered healthcare professionals and an independent prescriber (doctor) to provide treatment for an individual patient, with that patient's agreement, through a written clinical management plan. The Supplementary Prescriber can alter dose, remove or write prescriptions according to that plan.
Independent Prescribing involves taking full responsibility for prescribing decisions and autonomously writing prescriptions.

APPENDIX 2

Main conditions and medicines – physiotherapy

System	Medicine category	Indicative conditions	Evidence/guidance
Gastro-Intestinal System	Mucosal protectants	Chronic bowel conditions Stroke care and rehabilitation Chronic pain conditions requiring opioid analgesia use MSK conditions requiring NSAID Respiratory conditions where reflux is a contributing factor e.g. asthma	NICE CG017 (dyspepsia)
	Oral rehydration therapy	Conditions causing acute uncomplicated diarrhoea e.g. overseas travel	
	Anti-motility Laxatives	Urinary/faecal incontinence where constipation is a factor	NHS Clinical Knowledge Summaries (CKS) for Constipation

System	Medicine category	Indicative conditions	Evidence/guidance
Cardiovascular System	CPR adrenaline Anticoagulants	Cardiac collapse Stroke Post-operative conditions with prolonged reduced mobility	NICE CG8 (MS); NICE CG68 (Stroke); NICE CG35 (PD) NICE CG92 – VTE prevention NICE CG5, chronic heart failure NHS Clinical Knowledge Summaries (CKS) for Stroke and TI
Respiratory System	Short and long term b2 agonists Antimuscarinics Theophyline Combination preparations Corticosteroids Cromoglycants Anaphylaxis Respiratory stimulants	Asthma COPD Bronchiectasis Management of ventilated patients in acute settings. Cystic fibrosis Palliative Care	NICE CG101 (COPD); CG69 (RTI Antibx usage) British Thoracic Society guidelines NHS Clinical Knowledge Summaries (CKS) for Asthma COPD BTS/SIGN guidelines chronic asthma

System	Medicine category	Indicative conditions	Evidence/guidance
Respiratory System (continued)	Oxygen	As required for short-term, long-term, ambulatory, and ventilated use in patients with traumatic, short-term, long-term, and terminal respiratory conditions	
	Mucolytics		
	Expectorants		
	Humidification		
	Decongestants		
	Oral hygiene		
	Oral candida		
	Oral inflammation		
	Other – tracheotomy maintenance	Oral preparations for ventilated patients	

System	Medicine category	Indicative conditions	Evidence/guidance
Central Nervous System	Neuropathic pain medicines e.g: Tricyclic antidepressants	Chronic pain management	NICE CG96 (neuropathic pain)
		Pelvic pain – Women's health	British Pain Society Guidelines for opoid use in pain management
		End of life or chronic conditions	
		Respiratory distress	
		Chronic pain services	
		Neurological dystonias	
		Chronic pelvic pain/ vulvydynia	
	Non-opioid analgesics	Simple pain	WHO analgesic ladder
		Chronic pain	
		Chronic pelvic pain	
	Opioid analgesia	Post-operative care	
		Oncology services	
		End of life care	
		Chronic pain services	
		Continence services	

System	Medicine category	Indicative conditions	Evidence/guidance
Central Nervous System (continued)	Anti-migraine drugs	MSK pain services e.g. headache	
	Anti-epileptics	Neurological physiotherapy – tonic-clonic seizures	
	SSRIs	Stress urinary incontinence	
	Anti-emetics	Nausea and vomiting from – surgery/from opioid analgesia use/ stomach upsets	
	Torsion dystonia	Adult and paediatric neurological physiotherapy – spasticity	Royal College of Physicians – Spasticity in Adults – Management Using Botulinum Toxin
		Torticollis, dynamic equinus foot, hemi facial spasm, hyperhidrosis	

System	Medicine category	Indicative conditions	Evidence/guidance
Urinary tract Disorders	Anti-muscarinic agents Topical oestrogens/ Non-hormonal moisturisers Vaginal/vulval candidiasis	Detrusor instability Urinary frequency Urinary incontinence Vaginal atrophy Fungal infections Interstitial cystitis	NICE CG49 (Faecal Incont); NICE CG97 (Lwr Urinary tract infect in men); NICE CG40 (Stress Urinary Incont) NHS Clinical Knowledge Summaries (CKS) for UTI

System	Medicine category	Indicative conditions	Evidence/guidance
Musculoskeletal and Joint Disease	Local corticosteroid injections	Local inflammatory disorders of joints and/or soft tissues e.g. OA	NHS Clinical Knowledge Summaries (CKS) for: Acute LBP chronic LBP Sprains and Strains Neck Pain OA Headache NSAIDS
	NSAIDs	Rheumatic diseases	
	Rubefacients	Local inflammatory disorders and injuries of joints and/or soft tissues e.g. strains, sprains, muscle and ligament tears, swelling, bruising	
	Nutirceuticals		
	Systemic corticosteroids		
	DMARDS	Degenerative joint disorder/soft tissue injuries	British Society for Rheumatology DMARD guidelines
	Skeletal muscle relaxants	Systemic inflammatory disorders/connective tissue disorders	
		Neurological dystonias e.g. stroke/head injury	
	Bisphosphonates	Osteoporosis	NICE TA160/TA161 – Osteoporosis

System	Medicine category	Indicative conditions	Evidence/guidance
Anaesthesia	Sedatives – Benzodiazepines	Pre-operative anxiety Chronic muscle spasm Vulvydynia Respiratory distress, e.g. end of life care	
	Local Anaesthesia	Local inflammatory disorders of joints and/or soft tissues Conditions requiring ventilatory support via ET tubes	
	Entonox	Acute severe pain	
Other injectable medicines	Sodium chloride 0.9% for injection Water for injection	Associated with injection therapy Associated with respiratory care	

System	Medicine category	Indicative conditions	Evidence/guidance
Antimicrobials	Antibiotics inhaled, oral, nebulised, topical	Post-operative infection UTI URTI/LRTI Skin infections Throat infections Gastroenteritis Cellulitis Post-injection infection (rare)	NICE GC74: Surgical site infection HPA Primary Care Guidance – Management of infection guidance for Primary Care consultation and local adaptation
Others	Smoking cessation Obesity management		NICE TA39 & 123