Summary of Public Consultation on Proposals to Introduce Independent Prescribing by Physiotherapists

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Contents

Executive Summary

The purpose of this document is to provide a summary of the responses given to the public consultation on proposals to introduce independent prescribing by physiotherapists.

Physiotherapists

Physiotherapy is a graduate profession which specialises in the diagnosis and treatment of 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.

Background to the Consultation

- 1999 Review of prescribing, supply and administration of medicines (Crown Report)[1]
  - The report's recommendations informed policy for non-medical prescribing to improve patient care, choice and access, patient safety, better use of health professionals' skills and more flexible team working
- 2009 Allied Health Professions prescribing and medicines supply mechanisms scoping project report[2]
  - Recommended that further work be undertaken to extend independent prescribing to physiotherapists
- 2010 Engagement exercise on proposals for prescribing by physiotherapists
  - 388 responses were received, 91% supported prescribing by physiotherapists and podiatrists
- 2011 Ministerial approval received to take the proposals to a full public consultation

Public Consultation

The public consultation on proposals took place between 15th September and 30th December 2011. The UK-wide consultation was issued jointly by DH and the MHRA and was published on the Department of Health website and consultation hub with a link on the MHRA website. Respondents were able to submit their feedback via an online portal (Citizen Space), by email or in hard copy. 689 responses to the consultation were received in total. 285 responses were received via the online portal, 381 responses were received by email and 23 responses were received in hard copy.

77 organisations and 612 individuals responded to the consultations.

There were 30 responses from Scotland, 32 responses from Wales, 9 responses from Northern Ireland and 542 responses from England. Additionally there were 16 responses from British or UK-wide organisations.

7 responses were received from outside of the UK, including 3 responses from the USA, 2 from Germany, 1 from the United Arab Emirates and 1 from India.

Summary of responses to the consultation

- **Independent prescribing**
  Of the 689 responses received in total 99% (680) of all respondents including

[1] Department of Health (1999), *Review of prescribing, supply & administration of medicines*, DH

[2] Department of Health (2009). *Allied Health Professionals Prescribing and Medicines Supply Mechanisms Scoping Project Report*. London, DH www.dh.gov.uk

organisations and individuals supported one of the options for extending independent prescribing by physiotherapists. Of those:

- Option 1 - 73% (56) of organisations and 63% (388) of individuals supported extending independent prescribing by physiotherapists from a full formulary for any condition
- Option 2 - 22% (17) of organisations and 17% (103) of individuals supported extending independent prescribing by physiotherapists from a specified formulary / specified conditions
- Option 3 & 4 - 4% (3) of organisations and 19% (113) of individuals supported Options 3 & 4 supported extending independent prescribing by physiotherapists from either a specified formulary for any condition or for specified conditions from a full formulary
- Option 5 - 1% (1) of organisations and 1% (8) of individuals supported no change

- **Controlled drugs**
  - 75% (58) of organisations and 89% (543) of individuals selected 'Yes' to the limited list of controlled drugs
  - 3% (2) of organisations and 3% (18) of individuals selected 'No'
  - 17% (13) of organisations and 4% (26) of individuals selected 'Partly' and 5% (4) of organisations and 4% (25) of individuals selected 'Neither agree nor disagree'

- **Mixing of medicines**
  - 82% (63) of organisations and 87% (534) of individuals selected 'Yes' to allowing physiotherapist independent prescribers to mix medicines
  - 3% (2) of organisations and 4% (24) of individuals selected 'No'
  - 9% (7) of organisations and 2% (13) of individuals selected 'Partly' and 6% (5) of organisations and 7% (41) individuals 'Neither agree nor disagree'.

Next Steps

The results of the public consultation were included in the presentation of the proposals to introduce independent prescribing by physiotherapists to the Commission on Human Medicines (CHM) for their consideration in May 2012.

The CHM recommendations were submitted to Ministers for approval and an announcement of the agreement to extend independent prescribing responsibilities to physiotherapists and for physiotherapist independent prescribers to mix medicines was announced in July 2012.

MHRA are taking forward the necessary amendments to medicines legislation. The changes are planned to come into force before the end of 2012. Amendments to NHS Regulations will be laid alongside wider amendments in April 2013.

Education programmes for physiotherapist independent prescribers will be approved by the Health Professions Council (HPC). Physiotherapists that successfully complete an HPC approved independent prescribing programme and have an annotation on the HPC register will be allowed to independently prescribe medicines within their scope of practice and competence.

Proposals for independent prescribing physiotherapists to access a limited list of controlled drugs will be made to the Advisory Council on Misuse of Drugs for their consideration and the Ministerial response to their recommendations will be announced subsequently.

Background

Physiotherapists

Physiotherapy is a graduate profession which specialises in the diagnosis and treatment of 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. Physiotherapists identify and maximise movement, performance and function through health promotion, preventative healthcare, treatment and rehabilitation using a variety of physical, electro-physical, cognitive and pharmaceutical modalities.

Physiotherapists currently use medicines through Patient Group Directions (PGDs), Patient Specific Directions (PSDs) and Supplementary Prescribing.

Each of these prescribing mechanisms have their benefits, but each is limited in the extent of its benefit to patients by restrictions to use that have become ever more apparent in the new health service provision architecture.

Independent prescribing would enable physiotherapists to close this gap in patient care, and in particular provide better access to services for patients in the community, those with access issues and for marginalised or transient groups such as travellers, migrant workers, homeless people, students and offenders.

Summary of Regulation and Governance

Physiotherapists are regulated by the **Health Professions Council** which approves education programmes, regulates members against standards of practice, monitors registration, annotation, fitness to practice and CPD.

The professional body for physiotherapists, **The Chartered Society of Physiotherapy**, supports professional development of its members, defines the scope of practice of both the profession and its individual members, and produces the Code of Professional Values and Behaviours and the Standards of Physiotherapy Practice for members[3].

Physiotherapist prescribing competency standards are defined by the **National Prescribing Centre's** 'Single Competency Framework for All Prescribers'[4].

The competency standards will be mapped to the draft Outline Curricula Frameworks for Independent Prescribing programmes, which will be maintained by the **Allied Health Professions Federation (AHPF)**[5] to ensure physiotherapist prescribing competency is consistent with all other prescribers. The AHPF provides collective leadership and representation on common issues that impact upon the 12 Allied Health Professions.

The **Department of Health** produces Implementation Guidance for all non-medical prescribers (including nurses and pharmacists) as well as 'Medicines Matters' to ensure effective local governance and clinical supervision for safe prescribing. These documents will be updated prior to the commencement of physiotherapist prescribing, the current versions can be found on the DH website[6].

The **National Prescribing Centre**[7] produces policies for Medicines Management governance, for the management of prescribers within organisations, they also provide guidance on 'Mixing

[3] To be published on the Chartered Society of Physiotherapy website prior to commencement of prescribing responsibilities. http://www.csp.org.uk/

[4] http://www.npc.co.uk/improving_safety/improving_quality/resources/single_comp_framework.pdf

[5] http://www.ahpf.org.uk/

[6] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/healthcare/medicinespharmacyandindustry/prescriptions/thenon-medicalprescribingprogramme/index.htm

[7] http://www.npc.co.uk/

of Medicines Prior to Administration in Clinical Practice' and 'Safer Management of Controlled Drugs' for primary and secondary care.

Local and regional management of prescribers is through organisations Medicines Management committees and by a network of Non-Medical Prescribing Leads.

Background to the Consultation: Scoping Study and Engagement Exercise

In 1999, the Review of Prescribing, Supply and Administration of Medicines by Dr June Crown CBE[8] noted the competence and autonomy of physiotherapists and specialist physiotherapists and recommended them, along with nurses and optometrists, for early implementation of Independent Prescribing.

In 2009 an Allied Health Professions (AHPs) Prescribing and Medicines Supply Mechanisms Scoping Project[9] was undertaken 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.

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 as follows:

- 388 (190 responses specific to physiotherapists) responses received in total
    - 17% from organisations
    - 83% from individuals
- 91% of the total responses supported independent prescribing by physiotherapists and podiatrists
- 2% of the total responses were in favour of no change
- 7% of the total responses were undecided or not selecting a preference

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

The Department of Health for England with support from the Medicines and Healthcare products Regulatory Agency agreed to take forward the public consultations on independent prescribing by physiotherapists, to improve patients health as part of the policy developments to make better use of clinicians' skills and to make it easier for patients to get access to the medicines that they need.

Independent prescribing may enable new roles and new ways of working to improve the quality of services – delivering safe, effective services focussed on the patient experience. It can

[8] Department of Health (1999), *Review of prescribing, supply & administration of medicines*, DH
[9] Department of Health (2009). *Allied Health Professionals Prescribing and Medicines Supply Mechanisms Scoping Project Report*. London, DH www.dh.gov.uk

facilitate 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 may also enhance choice and competition, maximising the benefits for patients and the taxpayer.

Consultation Process

General

The UK-wide consultation was issued jointly by DH and the MHRA and was published on the Department of Health website and consultation hub with a link on the MHRA website between 15th September and 30th December 2011. The proposed amendments to the Medicines Act (1968) are UK wide, while the amendments to NHS regulations governing those working in the NHS are country specific. The Devolved Administrations are represented on the Project Board and contributed to the proposals. Amendments to NHS regulations are matters for each country to take forward separately in England, Scotland, Wales and Northern Ireland.

Communications

Invitations to respond to the public consultation were sent to the Chief Executives of a wide range of organisations including Royal Colleges, regulators, professional bodies and national organisations. Wider engagement was made with NHS organisations, third sector organisations, patient groups, Arms Length Bodies and NHS Networks. A full list of the organisations invited to respond to the consultations is included in appendix A.

Communications were made to all NHS Trust Chief Executives via the Department of Health's 'The Week' publication in England. Notification of the consultations was also published on the DH and MHRA websites, with links on the professional body, National Prescribing Centre (NPC) and Health Professions Council (HPC) websites, Chief Nursing Officer's and Chief Health Professions Officer's bulletins. Devolved administration representatives communicated with local networks and stakeholders in their country.

Leaflets and posters were disseminated through various networks to frontline services for clinician, patient, carer and public engagement.

Methods

Respondents to the consultation could respond in one of the following ways:

1. By completing the online consultation using Citizen Space
2. By downloading a PDF copy of the reply form from the DH Consultations webpage and emailing the completed form to the AHP consultation mailbox
3. By printing the reply form or requesting a hard copy to complete and return by post

Consultation Questions

The consultation[10] on proposals to introduce independent prescribing by physiotherapists took place between the15th September to the 30th December 2011. Respondents to the consultation were required to give their name as well as a response to three main consultation questions. The three mandatory questions were:

[10] http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_129983

Question 1. Which is your preferred option for introducing independent prescribing[11] by physiotherapists

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

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

- Yes
- No
- Neither agree nor disagree
- Partly (please explain)

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?

- Yes
- No
- Neither agree nor disagree
- Partly (please explain)

The remaining questions asked as part of the consultation were as follows:

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?

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?

[11] Independent prescribing is defined as: Prescribing of medicines by an appropriate practitioner responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing medicines.

Respondents were also invited to provide comments on both the consultation generally and on additional draft documents:

General Comments:

If you have any comments relating to the Outline Curriculum Framework for Education programmes, please add them here.

If you have any comments relating to the Outline Curriculum Framework for Conversion Programmes, please add then here.

If you have any comments relating to the Practice Guidance, please add them here.

Do you have any other comments you would like to make in relation to this consultation?

Consultation Responses

The consultation received 689 responses in total. 285 responses were received via the online portal (Citizen Space), 381 responses were received by email and 23 responses were received in hard copy.

30 responses were received from Scotland, 32 from Wales, 9 from Northern Ireland and 542 from England. Additionally there were 16 responses from British or UK-wide organisations, and 53 respondents did not specify their location.

The consultation received 7 responses from outside of the UK, including 3 responses from the USA, 2 from Germany, 1 from the United Arab Emirates and 1 from India.

77 organisations responded to the consultation and 612 responses were received from individuals of which 22 were from patients, carers or members of the public while 559 responded as a health or social care professional including; doctors, nurses, pharmacists, and Allied Health Professionals. Additional data on the respondents to the consultation is included in appendix C.

The responses were categorised into 5 groups; groups 1 to 4 comprise all of the organisational responses, sorted by organisation type while the 5th group includes all individual responses. Appendix D lists all organisational responses to questions 1, 2 and 3.

Table 1. Groups by type:

Group 1	National Organisations; Professional Bodies; Royal Colleges; Regulators; Government & Arms Length Bodies
Group 2	Allied Health Professions Organisations and Professional Bodies
Group 3	Higher Education Institutions
Group 4	Equality Groups; SHA AHPs; Third Sector Organisations; Patient Groups; Service Providers
Group 5	Responses from individuals

There were five options for respondents to select in Question 1.

Table 2. Question 1 Options

Option 1.	Independent prescribing for any condition from a full formulary (BNF).
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 (i.e. no change to the prescribing rights of physiotherapists)

Summary of Responses by Question

Responses to Question 1 'Which is your preferred option for introducing independent prescribing (IP) by physiotherapists?'

Table 3: Independent Prescribing Options Among All Groups

	Organisations										Individ's			
	Group 1		Group 2		Group 3		Group 4		All Orgs		Group 5		Total	
Option	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
Option 1	8	53%	12	86%	5	100 %	31	72%	56	73%	388	63%	444	65%
Option 2	6	40%	2	14%	0	0%	9	21%	17	22%	103	17%	120	17%
Option 3	1	7%	0	0%	0	0%	0	0%	1	1%	65	11%	66	10%
Option 4	0	0%	0	0%	0	0%	2	5%	2	3%	48	8%	50	7%
Option 5	0	0%	0	0%	0	0%	1	2%	1	1%	8	1%	9	1%
Total:	15		14		5		43		77		612		689	

Option 1: IP for any condition from a full formulary

The national organisations in Group 1 were mainly split between Option 1 and Option 2 with 8 (53%) and 6 (40%) of responses respectively. Respondents in Group 1 representing professional regulators and professional representative bodies; the **Royal College of Anaesthetists**, **Royal Pharmaceutical Society** (RPS), the **Nursing and Midwifery Council** (NMC), the **Care Quality Commission** (CQC), the **Public Health Agency (Northern Ireland)** (PHA) and the **Health Professions Council** (HPC) supported Option 1.

Option 1 was favoured by organisations among Groups 2, 3 and 4 more than Group 1 with 86%, 100% and 72% respectively.

The flexibility offered by Option 1 was a major theme in the physiotherapist consultation. Comments often stressed that this is only within the practitioner's scope of practice and competence.

> *We support the proposal for appropriately trained physiotherapists to be able to prescribe independently any medicine for any condition within their competence.*
> ***Royal Pharmaceutical Society***
>
> *This is a logical development to enable patients to receive complete episodes of care by registered healthcare practitioners working within their own specialist competencies.*
> ***Care Quality Commission***
>
> *It is important that physiotherapists prescribe only within their clinical competence.*
> ***College of Optometrists***
>
> *The regulatory and governance processes already in place for physiotherapist prescribers require that they only prescribe within their scope and practice and clinical speciality.*
> ***Nursing and Midwifery Council***

Prescribers prescribe within their competency so a full formulary will enable physiotherapists in different specialisms. Existing CPD requirements ensure it is safe and effective. Independent prescribing will enable effective patient management and good use of resources. It is cost effective and will reduce GP appointments "enabling one stop shops" and excellent customer service. Physiotherapists are effective prescribers and may prescribe less than GP's as it is utilised to facilitate a treatment programme.
Cambridgeshire Community Services NHS Trust

Any restriction placed on physiotherapist prescribing should be at the discretion of the employing organisation, as is the case for nurse and pharmacist independent prescribers. Any legislative restriction may result in further impediments to good practice and delays in patients accessing medicines as there are under existing supplementary prescribing processes. In order to develop clinical services, utilise physiotherapists' expertise, fully implement appropriate skill mix, and future-proof prescribing arrangements, there should be no legal restriction on formulary or conditions that may be treated.
Central Manchester University Hospitals NHS Foundation Trust

This will facilitate services to be developed to meet local needs in most flexible and appropriate way.
When prescribing it is always fundamental that clinicians work within their area of expertise and competency. Therefore by restricting conditions or formulary (breadth of prescribing) in reality this only places restriction on practice and patient access without actually improving patient safety.
Creating restrictions and differences in prescribing practice can cause patient anxiety, confusion and loss of confidence.
Physiotherapist

Comments from organisations in support of Option 1 refer to the impracticalities of a ‘Specified Formulary’ at legislative level, but suggest that a full formulary, used within the scope of professional practice would be appropriate.

Nurse prescribing changed from a limited formulary to independent prescribing. A report of the evaluation of the effectiveness shows this to be the most effective mechanism, and minimises confusion about who may prescribe what and the need for regular updating of formularies to support best practice. Option one creates clear lines of professional responsibility and accountability.
NMC

We agree that specified formularies would quickly become out of date and would be difficult to administer.
RPS

The options for a limited formulary have previously been shown to lack the flexibility and responsiveness required of an effective and modern health care system. Restricted formularies do not allow for access to new medicines, or the replacement of medicines no longer available with viable alternatives, without having to undertake time consuming and costly consultations which would delay delivery of evidence based care. It would

require constant revision by the MHRA and CHM, and maintain unnecessary cost pressure on the Department of Health.
Allied Health Professions Federation

I think physios should be treated the same as other non-medical prescribers - all about area of competence.
Pharmacist

Comments supporting 'Any Condition' noted the impracticality of a limited list of conditions for physiotherapy at legislative level but with appropriate training and assessment.

Independent prescribing for any condition - with appropriate additional drugs and therapeutics training and qualification where necessary.
Royal College of Anaesthetists

To restrict access based on 'condition' would be problematic, as many patients present with complex, mixed health problems which would be difficult to define within a specific area, thus restricting the care the practitioner might otherwise be able to offer. Both podiatrists and physiotherapists work in a variety of specialist areas of practice, and would not easily 'fit' into a restricted condition- led formulary. Risks would arise with the governance and monitoring of such a list.
Allied Health Professions Federation

Physiotherapists are required to diagnose and treat a range of conditions and may develop a specialism in a particular area that may not be covered by the majority of physiotherapists. We support option one as long as the prescriber has a scope of practice and a mentor and the prescribing is monitored by their host organisation.
NHS Hertfordshire

Restricting access to medication based on "condition" would be problematic as many patients present with complex health needs which would be difficult to define in a specific area. Physiotherapists work in a variety of specialist areas of practice, and would not easily 'fit' into a restricted condition- led formulary. Risks would arise with the governance and monitoring of such a list. The uncertainty created would be likely to lead to limited uptake by the practitioner as it may not be seen to be clinically useful to their employing organization as it may not be consistent with the model of service delivery.
Doctor

To limit Physiotherapists in the range of drugs they can prescribe or to restrict the type of conditions they can prescribe for is tantamount to making this exercise pointless. Physiotherapists work in many different areas not specifically listed in the executive summary including my own area of Rheumatology others have slight twists to their jobs that could never be accounted for.
In addition different specialities and even different regions use different drugs in different ways to treat their patients if the formulary is limited that potentially returns the patient right back to where they started having to see their GP wasting time and money.
Physiotherapist

A number of comments reflected the need for and ability to provide good governance and safe prescribing with Option 1.

> *We are reassured to note that the same standards would apply regardless of whether the physiotherapist works in the NHS, independent or other settings.*
> ***NMC***

> *Robust clinical governance arrangements are vital for ensuring safe and effective prescribing practice. Irrespective of the option which is chosen, professional regulation will make sure that the public is protected and that independent prescribers meet the appropriate standards.*
> ***Health Professions Council***

> *This can then be managed locally through existing governance arrangements of Non medical prescribers.*
> ***Birmingham Community Health Care NHS Trust***

> *Implementation of Nurse and Pharmacist prescribing has shown that it is safe and effective and supports timely access to service and medicines. The other options create too many limitations and increase the administration burden and may inhibit or reduce potential benefits of efficiencies for both patients and the NHS.*
> ***NHS Greater Glasgow and Clyde***

> *This allows flexibility for prescribing to develop within the service in the future without waiting for legislation to change. The organisation has the responsibility to ensure the governance controls are in place for safe prescribing.*
> ***Bridgewater Community Healthcare NHS Trust (Halton and St Helens Division)***

> *Chartered Physiotherapists are bound by a Code of Professional Conduct which prohibits them from practising outside the scope of their training. This is regulated by the Health Professions Council. In practice, this means that physiotherapists work within specialist fields. Prescribing requirements will fall within those fields. Whilst there could be a case for restricting prescribing rights to either a specified range of conditions or from a specified formulary, this may be difficult to either formulate comprehensively or to police. If specification is the preferred option, specification of the type or range of conditions would seem most sensible, allowing access to a full formulary.*
> ***Physiotherapist***

There are a number of themes emerging from the responses in relation to Option 1. These include the opportunity to redesign services, improve patient access to medicines, multi-disciplinary and flexible working.

> *The Public Health Agency in Northern Ireland (PHA) prefers Option 1: Independent prescribing for any condition from a full formulary. This will enable new roles and new ways of working to improve quality of services focused on patient experience and is also shown in the impact assessment to provide the greatest financial saving.*
> ***Public Health Agency (Northern Ireland)***

Option 1 will support both workforce redesign inter professional working as well as being patient centred. It would increase patient choice both in terms of location and provider and will be more likely to be taken up by employers so enhancing service delivery.
British and Irish Orthoptic Society

In the next decade with increasing squeeze on medical services physiotherapists prescribing will be a more cost effective means of getting quality care to a larger number of frail individuals who are unable to access medical services. It is only by having the widest remit possible that physiotherapists will be able to take up this challenge.
Physiotherapist

Patient benefit and improved care were also key themes in response to option 1.

We believe this will support patient care by enabling patients to receive the care and medicines they need from appropriately trained physiotherapists.
Royal Pharmaceutical Society

For physiotherapists, option 1 would optimize the advantages of workforce redesign and encourage more flexibility in roles, enabling a more flexible approach in facilitating the delivery of care which is in line with current government policy. For example, services should be patient-centred where patients receive the right treatment, at the right time, in the right place and the Individuals delivering this care should be selected due to their competency. The ability to provide autonomous delivery of care from assessment to diagnosis and treatment would be hindered by options other than option 1. Without this ability there are going to be delays in getting the correct treatment and there will be duplication of efforts by healthcare workers to achieve the successful outcome for the patient.
Derby Hospitals NHS Foundation Trust

To allow a more efficient patient care pathway. Allow an increased quality of care for patients in the outpatient setting.
Physiotherapists are often limited by not being able to provide simple medicines for respiratory patients in hospital such as Oxygen or nebulizers. Allowing physiotherapists to prescribe these medicines would mean patients wouldn't need to wait for a doctor to prescribe them. Meaning patients conditions would be treated before they worsened. In addition this would considerably reduce the strain placed on doctors.
Physiotherapist

Option 2: Independent prescribing for specified conditions from a specified formulary
Group 1 organisations were supportive of independent prescribing and most (40%) favoured Option 2 - specified conditions from a specified formulary; the **British Medical Association** (BMA), the **Royal College of General Practitioners (RCGP), the Royal College of General Practitioners (RCGP) Wales, the Royal College of Physicians of Edinburgh and the Health and Social Care Board, Northern Ireland.**

Other organisations including a number of NHS trusts also supported this option. The themes that emerged from comments reflected the need for physiotherapists to work within their scope of practice and competence, prescribe medicines from a limited formulary relevant to their

practice, provide good communication of their prescribing to GPs and other relevant clinicians to ensure patient safety.

Difficult for practitioners to access a record of what the patient is actually taking so risk of adverse interactions. Drugs may have been prescribed previously and been ineffective or patient has had adverse effects. The prime record should be the GP held record (hopefully patient held in the future). Doctors have had more extensive training to understand the way diseases and conditions interact and are aware of other influences on health and how individuals may react to conditions. We would wish to see a limited list of drugs which physiotherapists may prescribe with clear clinical guidelines as to what is safest and most effective which would presumably be covered in the advanced training.
Royal College of General Practitioners Wales

We can see the advantages of allowing physiotherapists and podiatrists to prescribe drugs for specific conditions related to musculoskeletal problems. However, as mentioned above, we would strongly emphasise the importance of communication with GPs about prescribing decisions made so that the GP record can be kept up to date to avoid adverse incidents.
Royal College of General Practitioners

It is the clear view of the RCPE Fellows that Option 2 (independent prescribing for specified conditions from a list of specified medicines) is preferred for a variety of reasons. It is not considered appropriate that physiotherapists should be able to prescribe from a full formulary (BNF). Numerous potential dangers exist for patients in relation to the limitations of ability to diagnose and limitations in knowledge of certain medical conditions. The risks of medication errors increase with the number of individuals able to prescribe for any particular patient and this is compounded by the lack of formal extensive training of this group of health professionals in relation to prescribing and therapeutics.
Royal College of Physicians of Edinburgh

The BMA is open to the idea of extending prescribing rights to appropriately qualified and experienced healthcare professionals to improve the safety, effectiveness, patient experience and productivity of healthcare. Therefore, we believe that healthcare professionals who are not doctors, such as physiotherapists, should only be permitted to prescribe from a limited range of drugs as is the case for dentists.
Physiotherapists will be prescribing within a particular range of circumstances, and so it is more appropriate for them to operate within the specific boundaries of a limited formula reflecting their competencies. The limits of these competencies should be very clear, and should be subject to regular review. Prescribing must be done to recognised and accepted protocols.
BMA

Any prescriber must ensure that primary care is fully informed so that any interactions can be avoided and side effects recognised. It is good practice to draw up a list of what they feel competent to prescribe and for any prescriptions to be taken over a prolonged period it may be appropriate to ask the General Practitioner's views before starting to ensure that this fits with the overall plans for the patient.
Welsh Medical Committee

There are concerns relating to possible professional conflict regarding prescribing practice with GPs and clinicians in a community healthcare setting will not necessarily have access to patient records or be familiar with the patient's past medical history and previous, as well as current prescribed medication. This raises some concerns regarding the potential for prescribing errors as a result of drug interactions etc.
Somerset Partnership NHS Foundation Trust

As respiratory pt with Cystic Fibrosis the need to have specified medicines within specified list of conditions would i feel provide greater pt safety. Having a prescriber who knows individuals choice/preference will help further when making decisions on treatment. Patient history their experience very important.
Patient

Concerns about the knowledge of clinical pharmacology and examination and assessment skills are also reasons for preferring option 2.

Physiotherapists in pre-qualification education receive some limited training in diagnosis and treatment of common medical conditions but relatively little training in clinical pharmacology. The education programme paper (section 5) outlines that some pharmacology will be taught but not diagnosis or treatment of common medical conditions. Relevant physical examination skills are mentioned but it is not clear what this means, especially if it becomes possible to prescribe for all medical conditions. History taking, physical examination, investigation, diagnosis, drug treatment and other modalities of treatment are inextricably linked. It is questionable whether the drug treatment can be isolated and taught appropriately in such a limited programme as outlined in the papers.
Royal College of Physicians of Edinburgh

The BMA is also concerned about accountability and supervision, in particular in relation to physiotherapists working in the private sector. Independent prescribing, especially from full formulary, runs the risk of patients accessing inappropriate or unsuitable medication from a prescriber who will not have access to their medical records, or the knowledge and training to assess the impact of prescribing medication outside of their area of expertise.
BMA

Option 1 has the maximum flexibility but raises concerns that the physiotherapist may stray into areas of higher risk for the patient by diagnosing and prescribing for conditions outside their experience or training. There is also the risk of new prescribers over-treating conditions that may get better untreated. Option 2 would seem to give sufficient flexibility to use the skills of the physiotherapist without the risks but there is the issue of keeping the list up to date.
Welsh Medical Committee

> *Physiotherapists do not have a rudimentary understanding of pharmacology written into their undergraduate course. Therefore the formulary should be limited.*
> ***Pharmacist***

There was some misinterpretation over the terms 'any condition' and 'full formulary' with some respondents believing that it implied that physiotherapists would start treating conditions and prescribing medicines outside their scope of professional practice and competence. An assumption was made in the writing of the consultation documents that it was generally understood that all clinicians only work within their scope of competence and practice. It was therefore not explicitly referenced in the consultation documents and as a result some respondents choices of the independent prescribing options are influence by that interpretation.

> *Physiotherapists may lack the expertise to diagnose, manage, and treat diseases which lie outside of their speciality. Independent Prescribing for any condition could lead to situations where treatment is started inappropriately or where patients are demanding changes to treatment which may not be in alignment with other health care professionals (HCP) managing their routine care.*
> ***Napp Pharmaceuticals Ltd***

> *This is a significant change in the scope of practice and responsibility for this group of professionals and we feel that Option 2 provides a safe "starting" point.*
> ***Betsi Cadwaldr University Health Board***

> *It would be unlikely that a physiotherapist would require the full use of the formulary or be able to assess patients with some conditions.*
> ***Nuse/Health visitor***

86 physiotherapists also supported Option 2. Reasons include safety, working within scope of practice and competence and patient benefit.

> *Physiotherapists become very specialist in their particular field - which is often at the expense of other areas. For example if I am a specialist in back pain I would not anticipate sufficient expert knowledge to be prescribing for a respiratory condition and vice versa.*
> ***Physiotherapist***

Option 3: IP for any condition from a specified formulary

This option was supported by the Accountable Officers Scotland – Working Group within group 1, they were the only organisation to select this option.

Option 3 was the third most popular with individuals with 65 respondents selecting this option of which 58 were physiotherapists. Respondents identify some of the difficulties in a list of specified conditions but would prefer a limited formulary for use across the conditions that physiotherapists treat.

> *Some of the proposed options may lead to complicated monitoring i.e. if drugs are allowable for some conditions but not for others this will be difficult to administer. Option*

2, 3, 4 all have the possibility of restricting changes in future practice where the drugs available or conditions which can be treated are limited and may be unresponsive to change.
Accountable Officers Scotland - Working Group

There are some groups of drugs that a physio would be very unlikely to ever prescribe and therefore a formulary - which could just include a group of drugs rather than names drugs - would avoid any potential temptation to prescribe other meds for a patient. Stating groups of drugs rather than individual named drugs would mean less updating needed.
Pharmacist

Option 4: IP for specified conditions from a full formulary
This option was the least supported among those favouring some form of independent prescribing with no organisations in Group 1 favouring this option and only 2 organisations in Group 4 preferring it.

There were 48 (8%) responses from individuals supporting this option of which 40 were physiotherapists.

The comments tend to refer to the operational requirement for physiotherapists to work within their individual scope of practice and competence.

The role for physiotherapists within the healthcare team can be defined and a list of specified conditions would ensure clarity. However, limiting independent prescribers to a formulary may limit their ability to successfully utilise their prescribing rights to the maximum benefit. We therefore believe that they should have access to any medicine, and for their prescribing to be monitored by the employing organisation.
Norfolk Community Health and Care

Specialist physiotherapists for example in a respiratory setting can safely and effectively use a number of drugs in a defined setting when appropriately trained.
Doctor

To avoid future slowdowns with the introduction of new medicines. The limitation on the conditions to be treated would ensure competence, specialisation and safety. There could otherwise be a risk of physiotherapists taking on roles out of their scope to meet increasing demand and workplace pressure.
Physiotherapist

There are specific situations within physiotherapy where if feel it would be beneficial to be able to prescribe independently, such as nebulisers in a patients home or pain medication in OA. So the specific conditions are useful, but I don't feel IP would be useful for all situations and for all conditions.
However I feel that having the availability to prescribe for all conditions may cause Patients with self-referral opportunities to use Physio as another form or GP and may cause unnecessary referrals to arrive or requests being made.
Physiotherapist

Option 5: No change

None of the organisations in Groups 1, 2 or 3 preferred this option. Only 9 respondents in total chose Option 5 (No Change) and of those 8 provided comments, which are provided below.

> *The consultation is not clear as to the distinctions between the different settings that physiotherapists may work in. We would be content with option 2 in a secondary care setting as part of a multi-disciplinary team, but have significant concerns about primary care and independent sector, leaving us no alternative other than to say option 5.*
> ***Consortium of Local Medical Committees***
>
> *I believe the clue is in the name - i.e. PHYSIOtherapist should employ therapies which are physical/mechanical in nature, leaving drug treatment to other therapists who have specialised in that modality.*
> ***Pharmacist***
>
> *I think the amount of practitioners/health care workers that are now able to prescribe potentially harmful medications is damaging and I regularly see errors in prescribing causing more workload and headaches for General Practitioners and additional consultations from the public asking us to endorse/agree the appropriateness of the prescribing.*
> ***Doctor***
>
> *I do not believe the majority of physiotherapy is about or should be about medication. I have great fears of patients with renal impairment being pushed over the edge into acute renal failure by a short course of NSAIDs, and of COPD patients bouncing around on steroid doses and on and off inappropriate antibiotics because so many people are involved in prescribing them. Prescribing well is not easy, and as someone who currently teaches nurses who want to become independent prescribers, a lot of the time they are frankly unsafe.*
> ***Doctor***
>
> *I see no need for physiotherapists to be able to prescribe. They are by definition dealing with physical solutions to illness, not medical ones. Usually the doctor has already seen the patient and is prescribing the drugs the patient needs. If the doctor hasn't seen the patient and they need a prescription then they probably need their doctor to know this. Physiotherapists seeing patients with musculoskeletal problems don't need to prescribe, the patient can buy the 'Over the counter' medications they need. Those seeing patients with respiratory conditions would already have a GP or hospital doctor involved who would be prescribing and who would need to know if there was a deterioration and would happily prescribe what is needed. In these situations it is important for the patient that the physiotherapist is part of the primary health care team, not working separately. Patients need continuity, they need their GP to be involved in their care. Many patients have multiple chronic diseases and the GP is coordinating treatment for these. At a time of increasing shrinkage of the NHS budget, this means spending more money on training and maintaining good clinical care for no particularly good reason. Research has found no great benefits from nurses becoming prescribers. Prescribing goes up as they do not have the experience and training doctors have. Prescribing by nurses has also shown to be less appropriate. Again this is not good at a time of needing to think*

carefully about all our resources. I can only see that this will be very costly with marginal benefits.
Doctor

I don't feel it is appropriate to allow AHP's to add this to their skill list. In order to safely prescribe, there needs to be full access to patient's medical records and medication list such as GP notes. As the GP has overall responsibility for the patient, no change in medication or dose should be made without the GP's full knowledge, in which case, the patient should be seen by the GP in order to do this. There are multiple examples of mistakes in medicating patients when they have been admitted to, or discharged from, hospital where full access to a patients GP notes hasn't been possible. The only drugs that should be prescribed are for injection administration such as steroid and local anaesthetic for injections of musculoskeletal conditions by a trained AHP.
Physiotherapist

Prescription of med's has traditionally been out side of the physio's area of practise, I see no reason for this to change.
Physiotherapist

Physiotherapists should NOT prescribe.
Anon

Responses to Question 2 Do you agree physiotherapists should be able to prescribe a restricted list of Controlled Drugs with appropriate governance subject to separate amendment of appropriate Regulations?
Controlled Drugs (CDs) are subject to the additional requirements of the Misuse of Drugs Regulations 2001 which are the responsibility of the Home Office. If physiotherapists are approved to prescribe CDs independently, amendments would need to be made to the Home Office regulations and their equivalents in Northern Ireland following advice from the Advisory Council on the Misuse of Drugs.

Controlled drugs (CDs)
The consultation invited views on allowing physiotherapists to prescribe a very limited range of controlled drugs namely:

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

Table 4: Controlled Drugs Responses Among All Groups

CDs Option	Organisations										Individ's			
	Group 1		Group 2		Group 3		Group 4		All Orgs		Group 5		Total	
	Total	%	Total	%	Total	%	Total	%			Total	%	Total	%
Yes	7	47%	14	100%	5	100%	32	74%	58	75%	543	89%	601	87%
No	0	0%	0	0%	0	0%	2	5%	2	3%	18	3%	20	3%
Partly	5	33%	0	0%	0	0%	8	19%	13	17%	26	4%	29	4%
Neither	3	20%	0	0%	0	0%	1	2%	4	5%	25	4%	39	6%
Total:	15		14		5		43		77		612		689	

Respondents that <u>Agreed</u> to giving physiotherapists access to a limited list of Controlled Drugs

Of responses by Group 1 organisations 7 (47%) supported access to the limited list of Controlled Drugs proposed. There were 5 (33%) responses which only partly supported the proposals. Concerns were expressed about some of the medicines specified. It was also stressed that prescribers practice within their scope of professional practice and competence within robustly governed settings.

The benefit to patients and the efficient use of physiotherapist's skills when used within their scope of competence and with appropriate governance in place were reasons specified.

> *We agree that physiotherapists should be able to prescribe the restricted list of Controlled Drugs subject to separate amendment of appropriate Regulations.*
> ***Royal Pharmaceutical Society***
>
> *The PHA agrees physiotherapists should be able to prescribe a restricted list of Controlled Drugs with appropriate governance subject to separate amendment of appropriate Regulations as this will benefit patients.*
> ***Public Health Agency Northern Ireland***
>
> *Physiotherapists are currently able to prescribe controlled drugs through supplementary prescribing. The conditions listed in the consultation document appear relevant and should help to improve the patient experience.*
> ***Nursing and Midwifery Council***
>
> *There is clear and strong justification for independent prescribing physiotherapists to be able to prescribe from the identified (and short) list of Controlled Drugs. Patients who need prescriptions of these drugs are those in acute or chronic pain, often severe. In addition, a proportion will be in the end of life stage of care. The quality of care and the quality of (remaining) life can be significantly enhanced by rapid access to the identified drugs, and independent prescribing physiotherapists are ideally placed to facilitate such access.*
> ***The AHP Professional Advisory Board***
>
> *Physiotherapists can currently do this via supplementary prescribing and so should continue to be able to do so with independent prescribing within their competence.*
> ***Robert Gordon University***

Drugs become Controlled Drugs because of concerns around misuse and governance. These drugs are not specially dangerous or toxic and if I am happy (for example) for an AHP colleague to prescribe prednisolone, then I would have less concern for them to prescribe (for example) buprenorphine.
Doctor

In law all independent prescribers should have the same privileges so that patients and carers are not confused. However the prescribing of controlled drugs must only be provided according to service need and where the physiotherapist is deemed to be therapeutically competent.
Nurse/Health Visitor

Provided it is within their sphere of competence and knowledge, then it should be allowed, as management of pain is part and parcel of their role.
Pharmacist

Respondents that <u>Disagreed</u> to giving physiotherapists access to a limited list of Controlled Drugs

None of the organisations in group 1 explicitly selected 'No' to the proposals however there were some concerns about the use in practice that were indicated in the comments. There were only two organisations that selected 'No' to the proposals on controlled drugs.

No, we do not believe that this list is appropriate. In our area GPs are being strongly encouraged not to prescribe some of these drugs on cost, safety and clinical grounds. Why should physiotherapists be allowed to do so? Who would be responsible for the monitoring of patients on these drugs? Who would be taking clinical responsibility? Would physiotherapists be taking out full medical defence cover? Who is going to take responsibility in the case of addiction?
Some of the drugs mentioned are currently only used in palliative care.
Consortium of Local Medical Committees for Lancashire & Cumbria

We are concerned about the list of CDs that may be prescribed by physiotherapists, as this may lead to patients having conditions being treated in isolation by different health professionals. We would envisage that in general the management of chronic pain should remain the responsibility of the GP.
Norfolk Community Health and Care

I think this is very unwise. It is difficult work looking after patients on controlled drugs with the problems around dependence. Some patients who become dependant become adept at obtaining further supplies of the controlled drug even when they don't need it. Any patient needing a controlled drug needs to be under the care of their GP or hospital doctor and to have only that person prescribing. Multiple prescribers will lead to increased work to coordinate and ensure the patient is receiving the correct and safe amount of the drug. I think this proposal is very unwise and not in the patients or the publics interests.
Doctor

Feel this requires more background knowledge of conditions and patients than physiotherapists always hold.

Nurse/Health Visitor

There were 18 individuals that selected 'No' to giving physiotherapists access to a limited list of controlled drugs. The majority of respondents that did not agree with the list considered the list to be insufficient for the needs of the profession in practice these were mainly physiotherapists.

Respondents that Partly agreed to giving physiotherapists access to a limited list of Controlled Drugs

Of those respondents that only partly agreed with the proposals to give physiotherapists a limited list of controlled drugs there were some key organisations including the **BMA** and the **Royal College of General Practitioners**, **Health and Social Care Board, Northern Ireland**.

Generally we should be trying to reduce the use of benzodiazepines but we support their short term use as muscle relaxants. We consider diazepam to be sufficient for this purpose. We accept that patients may experience a lot of pain with musculo-skeletal problems and we would support prescription of a short supply of stronger analgesia such as dihydrocodeine if appropriate. We believe long term prescribing should be undertaken by the GP.
Royal College of General Practitioners Wales

The consultation clearly supports the use of a range of controlled drugs. Much of the opiate prescribing would be for non-malignant pain, already an area where there is poor knowledge and inappropriate use of medicines. Fentanyl patches (and assorted other formulations) are a good case in point. It is specifically suggested that controlled drugs would be used in chronic respiratory disease; this we believe to be controversial without specific checks to ensure patient safety. It is difficult to believe that there is much need for opiate prescribing in palliative care (of any underlying condition) without the involvement of a doctor. The College would support the prescribing of Controlled Drugs by physiotherapists in hospitals, particularly in the management of postoperative pain, but has reservations about physiotherapists outside managed clinical environments generally having access to this type of medication. Benzodiazepines are included presumably as muscle relaxants and hypnotics, but the first is borderline useful at best and the second should be discouraged, and not available to healthcare professionals without a good grounding in pharmacology.
Royal College of Physicians of Edinburgh

We think this is very rarely likely to be safe or appropriate. All these drugs are hazardous, both in combination with other diseases and in addictions. GPs have a better understanding of the patient's use of other recreational drugs and alcohol etc. If a patient needs e.g. Oramorph or Fentanyl they should see a doctor.
Royal College of General Practitioners

As stated in our response to the previous question, we believe that physiotherapists should be able to prescribe for specified conditions from a specified formulary. However, it is even more important to limit the quantity and strength of certain controlled drugs (e.g. diazepam) prescribable for an episode without seeing a GP. Doctors would have a much better understanding of a person's use of other recreational drugs and alcohol.
British Medical Association

It is appropriate that physiotherapists prescribe from a restricted list of controlled drugs eg some codeine based preparations as long as the use is recommended by recognized guidance (national and local). The examples given in the consultation document would need to be tightly governed to ensure appropriate use. Medicines management teams are currently working to ensure that the use of benzodiazepines is appropriate given the abuse potential. It is unclear how frequently dihydrocodeine injection would be prescribed by physiotherapists but it may be more appropriate that a product of this nature to be reserved for use by a pain specialist. Appropriate product selections are required to ensure that best practice is being followed.
Health and Social Care Board, Northern Ireland

Should not include morphine preparations, fentany etc
Doctor

This should be the same for physiotherapists as it is nurses. However I do think that this list should be expanded to include common drugs like Tramadol. Many hospitals have there own policies restricting the prescribing of Tramadol.
Ideally this list in the appendix needs to be opened up to include more drugs and or more condidions.
Nurse/Health Visitor

Surprised oxazepam is not listed as this is commonly used locally for chronic respiratory patients who are anxious when they have difficulty breathing because of excess fluid in the lung.
Pharmacist

Responses to 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?

Under medicines legislation, mixing licensed medicines together, where one is not a vehicle for the administration of the other, creates an unlicensed product. Until 2009, only doctors and pharmacists had any scope to mix medicines although it occurs in many areas of clinical practice. The law was then amended to allow nurse and pharmacist independent prescribers as well as supplementary prescribers to mix. The consultation sought views on extending these provisions to allow physiotherapists to mix medicines and direct others to mix.

In response to the proposals for mixing of medicines by physiotherapists the Group 1 organisations were 9 responses and 60% supportive with 1 (7%) against, 2 (14%) partly in favour and 3 (20%) neither agreeing or disagreeing.

Across organisational groups 2, 3 and 4 the majority favoured the proposal with all respondents in groups 2 and 3 and 35 (81%) of group 4 supporting the proposals.

Individual respondents supported the proposals in the main with 534 (87%) in favour and 24 (4%) against.

Table 5: Mixing Medicines Responses All Groups

Mixing Option	Organisations										Individ's			
	Group 1		Group 2		Group 3		Group 4		All Orgs		Group 5		Total	
	Total	%	Total	%	Total	%	Total	%			Total	%	Total	%
Yes	9	60%	14	100%	5	100%	35	81%	63	82 %	534	87%	597	87%
No	1	7%	0	0%	0	0%	1	2%	2	3%	24	4%	26	4%
Partly	2	13%	0	0%	0	0%	5	12%	7	9%	13	2%	46	7%
Neither	3	20%	0	0%	0	0%	2	5%	5	6%	41	7%	20	3%
Total:	15		14		5		43		77		612	100%	689	

Respondents that Agreed to giving physiotherapists rights to the mixing of medicines

We are in favour of this proposal. If mixing was not allowed, physiotherapists could prescribe the individual drugs but not the mixture, clearly an inappropriate situation.
Royal College of Physicians of Edinburgh

The PHA agrees with making amendments to medicines legislation to allow physiotherapists who are independent prescribers to mix medicines prior to administration or direct others to mix.
Public Health Agency (Northern Ireland)

Such amendments should add clarity and allow effective and timely treatment, as well as provide a consistent approach amongst all independent prescribers, regardless of their professional group.
Nursing and Midwifery Council

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

I believe it appropriate for physiotherapist to be able to join Nurses and pharmacist who currently independent prescribers can mix licensed medicines themselves or direct others to mix for an individual patient.
Physiotherapist

Vital for carrying out injections of local anaesthetic and steroid if the patient is sensitive or allergic to one or more medicines within prepared combinations.
Physiotherapist

Respondents that Disagreed to giving physiotherapists rights to the mixing of medicines

A certain level of knowledge, training and expertise is required when mixing medicines as there is potential for interactions between mixed medicines, licensing, cost effectiveness etc. It seems inappropriate for physiotherapists as increasingly, other prescribers are being discouraged from doing so.

Health and Social Care Board, Northern Ireland

This again seems a step too far, i.e. effectively allowing the issuing of unlicensed medication.
Consortium of Local Medical Committees for Lancashire & Cumbria

Respondents that Partly agreed to giving physiotherapists rights to the mixing of medicines

Rarely. In limited situations (e.g. for lignocaine and corticosteroid) it may be appropriate.
Royal College of General Practitioners

Appropriately trained physiotherapists in specific settings where they are supported and supervised by medical professionals should be able to mix medicines in limited situations but should not be allowed to direct others. Directing others, especially if not suitable trained, could lead to errors in dosage or preparation, which may be dangerous to patients.
British Medical Association

The example given (steroid and local anaesthetic) seems sensible but other possibilities not so obviously sensible, and skills would rapidly be lost with "occasional mixtures"
Norfolk and Waveney Local Medical Committee

The organisation agrees to the mixing of drugs where there is accepted evidence of the stability of drugs and therapeutic benefit.
Kent Community Health NHS Trust

They should be able to mix meds but not sure why they would need to direct others to do so.
Bit of a discrepancy "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." but the MHRA advises that if you mix 2 drugs together you produce an unlicensed meds i.e. Lidocaine and Triamcinalone inj mixed together to administer are now and unlicensed meds. This caused problems with PGDs which cannot be for unlicensed meds.
Pharmacist

Where there is a precedent in medical practise for this- e.g. the mixing of lidnocaine and corticosteroid which is common practise in ortho/rheum conditions by Drs.
Physiotherapist

Responses to Question 4: Do you have any additional information on any aspects NOT already considered that could prevent the proposal for independent prescribing going forward?
18 organisations and 15 individuals responded to this question. The following examples illustrate some of the issues raised in response to this question:

The BMA has concerns about the unknown cost of reducing the continuity of care that a patient has with their GP and the unknown impact that that has on the value for money

of general practice. Although there may be a short term cost of a patient requiring a prescription from a GP, it keeps their relationship and knowledge about each other going which is useful when it comes to the trust needed to have an effective doctor-patient relationship. There has been a continuous reduction in continuity through successive policies aimed at choice which may ultimately be detrimental to making general practice work. This needs to be considered in the impact assessment in the light of evidence on continuity of care (see BMA report Improving the management of long-term conditions in the face of system reform, 2006).
We are also concerned about Clinical Commissioning Groups (CCG) prescribing budgets. We fear that GPs will lose even more control of the indicative prescribing budget. Currently GPs are pursuing prescribing savings actively through many means including a computer-based system called "Scriptswitch". We are concerned that in the future GPs could be influenced by a prescriber outwith[sic] the practice. The continuous increase in choice of providers, including prescribers, is undermining GPs' ability to make savings through commissioning with a limited budget. This also needs to be considered in the impact assessment.
British Medical Association

Although all physios will have a detailed understanding of anatomy, it is the application of pharmacology to physiology which gives the prescriber the ability to judge if a medication is safe. Also, how many physiotherapists are familiar with a broad reach of medications? However, if there is a limited formulary available to them which compliments the majority of their therapeutic specialty areas, eg cystic fibrosis/ other respiratory diseases/ musculoskeletal disorders, then I would very much welcome them being prescribers in their own right.
Pharmacist

Consideration needs to be given to physiotherapists requiring full access to GP and hospital records to ensure accurate drug and medical history rather than relying on patients to provide this
Physiotherapist

Consideration of physio impact when undertaking prescriber role, extra paper work, time away from normal patient duties. Care of wider patient group when prescribing.
Patient

Responses to Question 5: Do you have any additional information on any aspects NOT already considered that could support the proposal for independent prescribing going forward?
29 organisations and 72 individuals responded to this question. The following examples illustrate some of the issues raised in response to this question:

Physiotherapists should be given access to good IT to transfer prescribing information promptly to GPs but should not expect GPs to immediately respond. Patients should be asked for consent for physiotherapists to access the GP record.
Royal College of General Practitioners Wales

I believe that independent prescribing for optometrists has been an effective way of freeing up ophthalmologists' time and giving patients a more seamless path through treatment.
College of Optometrists

Physiotherapists often work where there is no ready access to doctors who would prescribe so patients will get a better service if they are allowed to prescribe for specific conditions or in specific circumstances.
Welsh Medical Committee

Recent evidence of the effectiveness of NMP prescribing by allied health professionals, including podiatrists and physiotherapists acting as Supplementary Prescribers indicates tangible benefits to both patient experience and service design and provision. The recent NMP Clinical Audit on prescribing in the North West has been demonstrated significant benefit to both patients and services. The results were based on 646 episodes of care of which 486 were podiatry and 160 physiotherapy.
One important result was the demonstration of a reduction in GP expenditure.
Doctor

My practice as a supplementary prescriber in a chronic pain team is impeded by the fact that nearly all my patients have multi pathologies who have frequent medication changes imposed by GPs, consultants and themselves in their OTC and herbal/alternative/illegal medicine usage. Currently under the cover of a CMP if anything should change it would require the check and often reassessment of the patient by our consultant to revalidate the CMP for this new presentation of interacting medications. This adds to his work load. The purpose of me being a prescriber was to take the 50% of simple dose titrations for pain management off his work list. This saving has yet to materialise due to the limits of working under a CMP as a supplementary and not an independent prescriber.
Physiotherapist

Would save time, money and be easier for the patient
Member of the public

Responses to Question 6: Does the consultation stage Impact Assessment document give an accurate indication of the likely costs and benefits of the proposal?
38 organisations and 46 individuals responded to this question. The majority of respondents felt that the consultation stage impact assessment (IA) gives an accurate indication of the likely costs and benefits of the proposal. The majority of comments were in support of the IA and the evidence used. Of the remainder, most were suggestions of potential benefits that could be included, and in general, these had already been addressed.

The following examples illustrate some of the comments given in response to the Impact Assessment:

Implementing independent prescribing does have a number of implications for us, which we have set out below. Some of these implications would have costs associated with them, for example, the costs associated with approving education programmes. However, these costs would not be a barrier to implementing independent prescribing.

If a decision was made to introduce independent prescribing for physiotherapists or chiropodists/podiatrists, we would need to set standards of proficiency for the new entitlement. Our Education and Training Committee has already agreed in principle to set standards for independent and supplementary prescribing together. We would need to consult on those standards for three months prior to publication.
Once these standards have been agreed, we would then need to approve education programmes in independent prescribing which met those standards. Where we would need to go and visit the programme, we would need 6 months' notice for the visit and up to 3 months following the visit to allow any conditions to be met and the education programme to be approved.
Education programmes would need to be in receipt of our approval prior to physiotherapists or chiropodists/podiatrists completing those programmes. Once we have approved the programme, registrants who successfully completed these programmes would have their entry on our Register annotated. They would then be able to prescribe independently.
Health Professions Council

The contributions to workforce redesign enabling role flexibility, reducing the duplication of services, enhance the patient pathway. Evidence from within the nursing profession's independent prescribing provision does appear to demonstrate cost benefits and improvement in patient satisfaction.
Also, supplementary prescribing through clinical management plans has been shown to be effective and has enhanced both the patient care pathway and made more efficient use of doctors' time. Therefore the move to independent prescribing would facilitate a significant move forward in the provision of efficient and effective care pathways for the benefit of patients.'
Powys Teaching Health Board

The assessment does not include the costs for a medical tutor/trainer. This will be a significant cost for those services in Community Care Trusts where a medic is not part of the current service provision and this expertise will need to be purchased. Also the cost of clinical governance/CPD, time away from clinical practice to maintain competence, in-house/external training.
Cambridgeshire Community Services NHS Trust

It is unlikely in the future that Designated Medical Practitioners would be available at 'no cost' as suggested in the impact analysis. In the past non-medical prescribers were often based in GP surgeries and time was given freely due to the shared benefits of the final outcome. However, physiotherapists are not always based in GP surgeries and therefore we would expect a cost to be attached to provision of DMPs. Indeed, this aspect of the training is likely to be a significant hurdle in rolling prescribing out to this group of staff.
Norfolk Community Health and Care

Designated Medical Practitioners (DMPs) may not be 'cost free' in community services, as we may need to 'buy in' their services from acute trusts or GPs
Oxleas NHS Foundation Trust

It doesn't accurately think about the costs of training and maintaining training. It doesn't take in to account the almost certain increase in prescribing that will occur You have

only to see what happened following nurses becoming prescribers - research shows a rise in prescribing but at the same time less good prescribing with unnecessary antibiotic prescribing in particular. Also more mistakes.
Doctor

Independent Physiotherapy prescribing would incur lower cost than consultant prescribing. The faster enhanced care would be likely to lead to better outcomes for patients and therefore ultimately lower medication costs.
Nurse/Health Visitor

Responses to 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?
20 organisations and 45 individuals responded to this question. The responses generally expressed the view that proposals could offer individuals of specific equality characteristics increased access to medicines resulting in better overall health outcomes for patients. The following responses illustrate some examples of the supporting evidence suggested:

On the face of it, this would be good for people with disabilities and people who do not have access to private transport. However, this may come with unforeseen costs; for instance, loss of ongoing relationships may make it more difficult to pick up depression. This could also apply to the minority or vulnerable groups in Question 8.
British Medical Association

A sizeable proportion of physiotherapists' work is with people with disabilities. Having access to an independent prescribing physiotherapist is likely to enhance the quality of support provided. Similarly, with older people and those in the end stages of their lives.
Allied Health Professions Professional Advisory Board

Independent prescribing would be likely to offer patients more equitable access to care from prescribing podiatrists or physiotherapists as the IP mechanism might enable existing mechanisms, such as the use of PGDs, to be superseded over time. PGDs currently tend to operate inconsistently over different geographical areas and across different PCTs. Independently prescribing professionals such as podiatrists or physiotherapists would also be empowered to provide services and care closer to patients' home, in line with the White Paper on Health & Social Care, saving both time and money, thus enabling a better quality of life for patients.
Allied Health Professions Federation

Independent prescribing would offer improved access to medicines for hard to reach populations (e.g. patients with a disability and those with mental health issues for whom attendance at a clinic is difficult) and for those at increased medication-related risk (e.g. residents in care homes and the housebound). The need for clinical management plans creates a significant barrier to effective prescribing at the point of need and may result in deterioration necessitating unscheduled admission. It would also offer a wider range of choice for patients since they would be able to access a complete episode of care from a single practitioner.
Central Manchester University Hospitals NHS Foundation Trust

Implementation of Non Medical Prescribing has been shown to have a positive impact on equality of care. The NHSGGC Strategy for Non Medical Prescribing underwent and Equality Impact Assessment which demonstrated the positive impact it would have on the ability of the organisation to improve the equality of the care delivered to patients in the NHS Board area.
NHS Greater Glasgow and Clyde

I am an independent nurse prescriber working in contraception and sexual health service and outreach into community settings and patient's homes. I am aware of how beneficial independent prescribing is to vulnerable patients, those who do not easily access mainstream health care settings, asylum seekers and other vulnerable groups. The opening up of this opportunity to Physiotherapists would benefits these groups.
Nurse/Health Visitor

Physiotherapists often build a strong professional relationship with patients especially those with long term conditions. Thus they are in a position to provide informed information within a relationship where an understanding of the patient's values has developed and therefore they are better able to prescribe accordingly.
Member of the public

Responses to 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, asylum seekers, children and young people, homeless and offenders?

32 organisations and 63 individuals responded to this question. The responses generally expressed the view that proposals could offer certain equality groups increased access to medicines resulting in better overall health outcomes for patients. The following responses illustrate examples of some of the supporting evidence suggested:

Access to physiotherapy is limited for these groups. We should wish to see increased access to routine physiotherapy as a priority.
Royal College of General Practitioners Wales

For allied health professional treating patients in the vulnerable groups listed above independent prescribing would mean these patients being able to be treated nearer to their primary medical care, so allowing more responsive treatment to be given probably with fewer visits and so enhancing the treatment given. Access to allied health professionals has been shown to be both cost effective and have substantial patient benefits and independent prescribing would enhance those services given.
British and Irish Orthoptic Society

I see these proposals as relevant and accessible to all members of the public as well as the professions. I do not envisage any barriers to any minority group. In addition, the development of self referral and community / outreach based services would be enhanced, enabling practitioners to offer a more comprehensive service to users in a setting of their choice.
Cardiff and Vale University Health Board

Many patients who attend for respiratory physiotherapy are suffering from shortness of breath and often have multiple co-morbidities.
They are often physically unable to make multiple visits to different practitioners for treatment and medications separately and I feel this places them at a disadvantage. For the elderly amongst this population, they are further disadvantaged by difficulties in transport and physical frailty making multiple appointments impossible.
For children suffering from respiratory problems, they rely on parental support and again, multiple appointments requires time off work for parents and this places them at a disadvantage.
Physiotherapist

Main positive benefit is easy access for any communities particularly those difficult to reach or engage with the medical profession.
Member of the public

General Comments

1. Comments relating to the Outline Curriculum Framework for Education programmes
30 organisations and 47 individuals commented on the Outline Curriculum Framework for Education programmes. The following are a sample of the comments provided in response to this document.

We are reassured by the reference to other regulatory standards for independent prescribers, and the consistency of approach amongst the health care professions. In particular, the eligibility criteria for admission to the education programmes that will prepare prescribers, and proposals for assessment.
Nursing and Midwifery Council

The outline curriculum framework reflects work already completed for AHP and Nursing non-medical prescriber professional groups. It is an extension of the supplementary prescribing framework already used by physiotherapy, podiatry and radiography with enhanced safe guards and requirements for independent prescribing.
North West AHP Non Medical Prescribing Network

The outline curriculum framework appears to provide a robust framework for the provision of training and education for independent prescribers, in line with existing frameworks for other NMP prescriber groups. It provides for the necessary extension to the supplementary prescribing framework already used by physiotherapy, podiatry and radiography, with enhanced safe guards and requirements for independent prescribing included.
Doctor

I do not consider that three years postgraduate experience is sufficient to allow safe prescribing by physiotherapists, particularly in view of the difficulty gaining relevant experience due to current employment climate and the loss of junior rotational posts. I would recommend a minimum of 5 years of postgraduate experience of which 2 should be in the relevant specialist field.
Physiotherapist

A number of Education Programmes deliver a standard curriculum framework to a range of healthcare professionals who acquire either an IP or SP prescribing qualification upon successful completion dependent on their profession. i.e. Physiotherapists on the same course with Nursing staff get a SP award whilst their Nursing colleagues achieve IP status. For those physiotherapy students who have completed such programmes and have secured SP status, careful consideration needs to be given in terms of what they would need to do to convert to IP.
Physiotherapist

2. Comments relating to the Outline Curriculum Framework for Conversion Programmes
23 organisations and 41 individuals commented on the Outline Curriculum Framework for Conversion Programmes. The following are a sample of the comments provided in response to this document.

It must be made explicitly clear that the conversion programme is to provide knowledge and skills in INDEPENDENT PRESCRIBING. It must not be used in a manner that leads participants to believe they are being re-assessed in either supplementary prescribing skills, or in their examination and diagnosis skills, which will have been covered in the SP programme. It must also focus on the legislative framework for IP and the regulatory standards for IP for physiotherapists as and when they are created. The distinction between IP and SP must be made explicitly clear.
Chartered Society of Physiotherapy

Clear guidance for supplementary prescribers to identify what they need to do to up-skill to independent prescribing is required, as they will have already covered the same theoretical content as independent prescribers.
If the conversion courses are to be at post-registration level (level 6), there would need to be clarity about why courses were available at level 7. This should not be different between the professions and level 6 and 7 should therefore be accessible to all professions.
The curriculum, while it maybe multiprofessional, requires to guide and support students to evolve within their scope of practice. This has been challenging within the existing supplementary prescribing courses. An emphasis on supporting students to self-direct and apply the principles of prescribing into their current and future context is needed e.g. students having the opportunity to discuss/ explore medicines directly pertinent to their post/ role. The work-based element of the course should be designed to support the student into current/ new service provision.
The curriculum should also enable students to identify sustainable infrastructure to support IP and repeated prescriptions. IP requires administrative processes in addition to the clinical skills. Without the supportive systems and processes the IP practitioners impact and effectiveness will be restricted.
Learning from other conversion courses is important here.
NHS Education for Scotland: AHP Team & Physiotherapy Education Advisory Group

I welcome the detail provided in appendix H. I welcome the clarity provided too in terms of learning outcomes, length of programme etc. In terms of assessment strategies proposed I applaud the proposal to have the converting supplementary prescribing

physiotherapist undertake assessment in practice with a designated medical practitioner using a portfolio approach. However I do not agree with the proposal for converting supplementary prescribing physiotherapists to undertake a further clinical examination as these students will have passed such an examination within their supplementary prescribing course undertaken at most within the last five years. Therefore to undertake a further examination would be repetitive and costly on both students, employers and course teams in terms of the support/time needed for such an examination. I believe the proposal to assess the converting supplementary prescribing in independent prescribing practice afford greater 'fitness for practice' than repeating a written examination. Finally when other non-medical prescribers converted this was not the practice for these groups.
Nurse/Health Visitor

I am extremely unhappy that physiotherapists have to undertake further training. I have recently completed and passed the same NMP course as many nursing staff. What would the conversion course entail? Is it not a waste of precious resources to make physiotherapists undertake further training when many of them have completed exactly the same course as nurse prescribers?
Physiotherapist

3. Comments relating to the Practice Guidance

24 organisations and 29 individuals commented on the Practice Guidance. The following are a sample of the comments provided in response to this document.

We are currently reviewing Standards of proficiency for nurse and midwife prescribers (NMC 2006), and Standards for medicines management (NMC, 2008) and will take the outcomes of this consultation into account.
Nursing and Midwifery Council

The RPS would be pleased to work with the Chartered Society of Physiotherapy to ensure that the areas of the proposed practice guidance which are relevant to pharmacists are in line with current practice and professional guidance for pharmacists.
Royal Pharmaceutical Society

The Health Ethics and Law network acknowledges that the professional guidance documents for both podiatry and physiotherapy offer clear guidance to both NHS and private practice practitioners, and offers a relevant governance structure for prescribing. It is comparable in the structure and content to other NMP professional and regulatory body guidance documents (such as that provided by the Nursing and Midwifery Council, and the College of Optometrists) for professions currently with Independent Prescriber members/registrants.
Health, Ethics and Law network, University of Southampton

This is extensive, clear and well written. It appears to cover all necessary areas.
Yeovil District Hospital NHS Foundation Trust

I applaud the production of appendix I. However this is long overdue for AHP prescribers. However until these good practice statements are converted into standards

regulated by the HPC the public will not be protected from physiotherapy prescribers in the same way the NMC/GMC protect the public from their respective prescribers.
Nurse/Health Visitor

4. Do you have any other comments you would like to make in relation to this consultation?
28 organisations and 52 individuals made other comments in relation to the consultation. The following are a sample of the comments provided in response to this question.

We welcome the proposals to undertake a random sample audit of continuing professional development, and the reference to the National Prescribing Centre competency framework. It may be helpful to be more explicit about the way in which the competency framework will be applied.
Nursing and Midwifery Council

We support an integrated approach to healthcare and believe that independent prescribing rights for physiotherapists will lead to improved patient choice and value for money for the NHS.
British Osteopathic Association

As an Executive Director of Therapies and Health Science within an integrated Health Board in Wales I am supportive of physiotherapists becoming independent prescribers (following appropriate training and annotation of register). I think this presents an enormous opportunity to enhance the quality of patient care across the UK and hope we have the opportunity in the future to enter discussion with Welsh Government to enable physiotherapists in the NHS in Wales to become independent prescribers. I have worked previously in England and the same reasoning and comments apply.
Cardiff and Vale University Health Board

We think that there should be more consistency in non medical prescribing training between professions (nurses, pharmacists and allied health professionals) and that the outline curriculum framework should be set centrally e.g. by the Department of Health rather than the professional regulatory bodies having slightly different curriculum frameworks.
Bromley Healthcare Community Interest Company Ltd

I am against this proposal. It is not in patient interests as it uses up health service budget, is likely to result in an increase in prescribing without additional benefit, and is not necessary.
Doctor

Physios are highly trained with good diagnostic reasoning and examination skills. Allowing them to prescribe will release their potential for the NHS and especially for community teams.
Doctor

I think in view of the rapid progression of various clinical roles in the NHS, along with the pressure on cost, it is imperative that legislation keeps up with these clinical roles. More and more physiotherapists are injecting and yet are unable to do so without the

supervision of doctors. This is a massive drain on resources and also creates difficulties with supervision for training. It is well known that physios are excellent at maintaining their competency in all areas of their practice, and the documents presented here, are comprehensive in ensuring that there would be adequate training and maintenance of their competency within this specific role.
Physiotherapist

It is a huge step forward for the improvement of patients care and the development of more economically sustainable treatment pathways in the NHS. It will need accurate monitoring to ensure physiotherapists do not exceed their scope of practice to meet increasing demand in the future.
Physiotherapist

I have experienced corticosteroid injections by a physiotherapist and was very happy with the result. It would have saved time though if the physio could have prescribed the medication directly.
Patient

Themes Arising from the Consultation

Several themes emerged from respondents' comments in addition to the option-specific themes. Comments regarding the potential benefits to patient care and training for independent prescribing were the most prevalent. There were also a large number of comments suggesting that proposals would lead to increased access to medicines for patients and the saving of GP time. A summary of each theme is outlined below in order of salience.

Patient benefit
168 respondents indicate that the introduction of independent prescribing by physiotherapists would benefit patients. More specific comments within this category include increased patient choice (11 respondents), improved patient experience (24), better standard of care (13) and more timely treatment (64).

Training/Education
153 respondents commented on training and education. A number were in relation to the importance of training and education as part of their option for independent prescribing, the mixing of medicines and access to controlled drugs. These comments broke down into the following themes:

1. Concern over the cost of training courses for independent prescribing and who would retain the burden of the costs (33)
2. Concern over the need to for supplementary prescribers to 'retrain' to become independent prescribers (20)
3. Expressions of confidence in the high level of education required to qualify as a physiotherapist (8)
4. Comments that respondents do not see the need to use the full BNF and that training to use it would be a waste (6)
5. Approval of the proposed independent prescribing curriculum (5)

Access to medicines
95 respondents felt that proposals would allow patients better access to medicines and would reduce additional appointments with GPs and the unnecessary time taken from their busy schedules. It was also noted that increased access to medicines would contribute to improved services particularly for disadvantaged or marginalised groups that struggle to access mainstream health services, e.g. the homeless or travellers.

Scope of Practice
61 respondents commented on the scope of practice of physiotherapists. The comments generally reflected the confidence in physiotherapists working within their scope of competence and practice and were used to support the option chosen whether it was for full formulary any condition or a more restricting option to match the scope of practice and competence.

Timely Treatment
A number of respondents identified the timely treatment of patient and the improved clinical outcome and patient experience as benefits of introducing independent prescribing.

> *Supplementary prescribing currently limits physiotherapists ability to prescribe as the practicalities of finding a doctor and the time taken to do a clinical management plan, means that this can only be offered to a few patients. Whilst this is a useful tool, especially if unusual drugs or drugs unfamiliar to the prescriber are being used, independent prescribing will enable more patients to have access to medication alongside Physiotherapy.* ***Cambridgeshire Community Services NHS Trust***

Communication and Information Sharing
There were a number of comments that stressed the importance of communication between clinicians, and prescribing decisions being communicated quickly and accurately to the patient's GP and other relevant clinical colleagues.

> *This is a logical development to enable patients to receive complete episodes of care by registered healthcare practitioners working within their own specialist competencies, both within and outside a formal multi-professional team, but also keeping other relevant members of the team appropriately informed on episodes of treatment also relevant to others caring for the same patient.* ***Care Quality Commission***

Patient safety
38 respondents express a belief that the proposed changes would be safe or increase patient safety. The reasons given include the specialist knowledge and skills that physiotherapists have in relation to their area of practice and experiential evidence in regard to nurse and pharmacist independent prescribing.

Risk to patent safety
15 respondents expressed concerns regarding patient safety due to difficulties in accessing patient information, knowledge of drug interactions and side effects.

Service redesign
37 respondents commented on the potential for service redesign which these proposals would enable. Reasons included the streamlining of care pathways, workforce redesign, multi-

disciplinary team flexibility, improved efficiency and responsiveness to patient needs in community care.

Governance
Comments in regard to governance included support for the governance framework in the CSP Practice Guidance, confidence that governance procedures for existing non-medical prescribers would be sufficient and appropriate, support for local governance arrangements at organisational level to ensure safety and concerns about the monitoring of practitioners by the regulator and in private practice.

Next Steps

Following Public Consultation

The results of the public consultation were included in the presentation of the proposals to introduce independent prescribing by physiotherapists to the Commission on Human Medicines (CHM) for their consideration in May 2012.

The CHM recommendations were submitted to Ministers for approval and an announcement of the agreement to extend independent prescribing responsibilities to physiotherapists and for physiotherapist independent prescribers to mix medicines was announced in July 2012.

The subsequent changes to the UK-wide legislation and NHS regulations in England will be amended accordingly. The NHS regulations in Wales, Scotland and Northern Ireland are matters for the devolved administrations.

Education programmes for physiotherapist independent prescribers will be validated by the Health Professions Council (HPC). Physiotherapists that successfully complete an HPC approved independent prescribing programme and have an annotation on the HPC register will be allowed to independently prescribe medicines within their scope of practice and competence.

Proposals for independent prescribing physiotherapists to access a limited list of controlled drugs will be made to the Advisory Council on Misuse of Drugs for their consideration and the Ministerial response to their recommendations will be announced subsequently.

Scope of physiotherapist independent prescribing

The scope of prescribing practice for physiotherapists within the boundaries of their individual professional practice and scope of competence may be defined as:

> **"The physiotherapist independent prescriber may prescribe any licensed medicine within national and local guidelines for any condition within the practitioner's area of expertise and competence within the overarching framework of human movement, performance and function."**

Amendments to Legislation and NHS Regulations

MHRA are taking forward the necessary amendments to medicines legislation. The changes are planned to come into force before the end of 2012. Amendments to NHS Regulations will be laid in April 2013.

Appendices

Appendix A: Consultation Dissemination List

The following tables list the organisations who were invited to respond to the consultation. Each of the following organisations were sent an email inviting them to respond to the consultation at the commencement of the consultation period and then a reminder during the final month of the consultation.

These organisations have been grouped according to the grouping method used among the organisational responses to questions 1, 2 and 3. The Group 3 Higher Education Institutions were informed via the Council of Dean's for Health communications network.

Group 1 Organisations	Category
Advisory Council on Misuse of Drugs	Government/ALB
Care Quality Commission	Government/ALB
Council for Healthcare Regulatory Excellence	Government/ALB
Health Protection Agency	Government/ALB
Local Government Association	Government/ALB
Medicines & Healthcare products Regulatory Agency	Government/ALB
Monitor	Government/ALB
National Audit Office	Government/ALB
National Patient Safety Agency	Government/ALB
National Institute for Health and Clinical Excellence	Government/ALB
National Prescribing Centre	Government/ALB
Association for Nurse Prescribing	National Organisations
Association for Palliative Medicine	National Organisations
Association of Anaesthetists of Great Britain and Northern Ireland	National Organisations
Association of Directors of Adult Social Services	National Organisations
Association of Directors of Public Health	National Organisations
Association of Surgeons of Great Britain and Ireland	National Organisations
British Medical Association	National Organisations
Community and District Nursing Association	National Organisations
Community Practitioners' and Health Visitors' Association	National Organisations
English Community Care Association	National Organisations
Family Doctor Association	National Organisations
GMB	National Organisations
Guild of Healthcare Pharmacists	National Organisations
National Council for Palliative Care (NCPC)	National Organisations
National Pharmaceutical Association	National Organisations
Primary Care Pharmacists Association	National Organisations
Registered Nursing Home Association	National Organisations
Royal Society for Public Health	National Organisations
Social Enterprise Coalition	National Organisations
Society of Local Authority Chief Executives	National Organisations
St John Ambulance	National Organisations

Group 1 Organisations	Category
Association of the British Pharmaceutical Industry	National Organisations
NHS Confederation	National Organisations
Social Partnership Forum	National Organisations
NHS Alliance	National Organisations
National Association for Primary Care	National Organisations
Arthritis and Musculoskeletal Alliance (ARMA)	National Organisations
National Rheumatoid Arthritis Society	National Organisations
Connecting for Health	National Organisations
General Pharmaceutical Council	Regulators
Health Professions Council	Regulators
General Medical Council	Regulators
Nursing and Midwifery Council	Regulators
General Optical Council	Regulators
Academy of Medical Royal Colleges	Other Professional Bodies/Royal Colleges
British Association of Dermatologists	Other Professional Bodies/Royal Colleges
British Dental Association	Other Professional Bodies/Royal Colleges
British Pharmacological Society	Other Professional Bodies/Royal Colleges
British Society of Gastroenterology	Other Professional Bodies/Royal Colleges
College of Optometrists	Other Professional Bodies/Royal Colleges
Royal College of Anaesthetists	Other Professional Bodies/Royal Colleges
Royal College of General Practitioners	Other Professional Bodies/Royal Colleges
Royal College of Midwives	Other Professional Bodies/Royal Colleges
Royal College of Nursing	Other Professional Bodies/Royal Colleges
Royal College of Obstetricians and Gynaecologists	Other Professional Bodies/Royal Colleges
Royal College of Ophthalmologists	Other Professional Bodies/Royal Colleges
Royal College of Paediatrics and Child Health	Other Professional Bodies/Royal Colleges
Royal College of Pathologists	Other Professional Bodies/Royal Colleges
Royal College of Physicians	Other Professional Bodies/Royal Colleges
Royal College of Psychiatrists	Other Professional Bodies/Royal Colleges
Royal College of Radiologists	Other Professional Bodies/Royal Colleges
Royal College of Surgeons (England)	Other Professional Bodies/Royal Colleges
Royal Pharmaceutical Society (England)	Other Professional Bodies/Royal Colleges
Royal Society of Medicine	Other Professional Bodies/Royal Colleges
College of Emergency Medicine	Other Professional Bodies/Royal Colleges

Group 2 Organisations	Category
Allied Health Professions Federation	AHP Professional Bodies
British and Irish Orthoptic Society	AHP Professional Bodies
British Association of Dramatherapists	AHP Professional Bodies
British Association of Art Therapists	AHP Professional Bodies
British Association of Prosthetists and Orthotists	AHP Professional Bodies
British Dietetic Association	AHP Professional Bodies
Chartered Society of Physiotherapy	AHP Professional Bodies
College of Occupational Therapists	AHP Professional Bodies
College of Paramedics	AHP Professional Bodies

Group 2 Organisations	Category
Institute of Chiropodists and Podiatrists	AHP Professional Bodies
Royal College of Speech and Language Therapists	AHP Professional Bodies
Society and College of Radiographers	AHP Professional Bodies
Society of Chiropodists and Podiatrists	AHP Professional Bodies
Association of Professional Music Therapists	AHP Professional Bodies

Group 4 Organisations	Category
King's Fund	Equality
Council for Disabled Children	Equality
Council of Ethnic Minority Voluntary Sector Organisations	Equality
Equalities National Council	Equality
Equality 2025 (UK Advisory Network for Disability Equality, hosted by the Office for Disability Issues at DWP)	Equality
Equality and Human Rights Commission	Equality
Men's Health Forum	Equality
Mental Health Providers Forum	Equality
National Centre for Independent Living	Equality
Race Equality Foundation (REF)	Equality
RADAR	Equality
Shaping Our Lives National User Network	Equality
National Care Forum (NCF)	Equality
Women's Health and Equality Consortium (WHEC)	Equality
NHS Partners Network	NHS
Strategic Health Authority - East Midlands	NHS
Strategic Health Authority - East of England	NHS
Strategic Health Authority - London	NHS
Strategic Health Authority - North East	NHS
Strategic Health Authority - North West	NHS
Strategic Health Authority - South Central	NHS
Strategic Health Authority - South East Coast	NHS
Strategic Health Authority - South West	NHS
Strategic Health Authority - West Midlands	NHS
Strategic Health Authority - Yorkshire and the Humber	NHS
SHA AHP East Midlands	SHA AHPs
SHA AHP East of England	SHA AHPs
SHA AHP London	SHA AHPs
SHA AHP North East	SHA AHPs
SHA AHP North East	SHA AHPs
SHA AHP North West	SHA AHPs
SHA AHP South Central	SHA AHPs
SHA AHP South East Coast	SHA AHPs
SHA AHP South West	SHA AHPs

Group 4 Organisations	Category
SHA AHP West Midlands	SHA AHPs
SHA AHP Yorkshire and the Humber	SHA AHPs
Action on Smoking and Health (ASH)	Third Sector
Age UK	Third Sector
Alzheimer's Society	Third Sector
Arthritis Care	Third Sector
Association for Real Change	Third Sector
British Cardiac Patients Association	Third Sector
British Heart Foundation	Third Sector
Carers UK	Third Sector
Consumers' Association	Third Sector
Diabetes UK	Third Sector
Macmillan Cancer Support	Third Sector
Marie Curie Cancer Care	Third Sector
Mencap	Third Sector
Mind	Third Sector
Nacro and Action for Prisoners Families	Third Sector
National Voices	Third Sector
Patients' Association	Third Sector
Princess Royal Trust for Carers, Crossroads Care and Carers UK	Third Sector
Royal British Legion and Combat Stress	Third Sector
Arthritis Care	Patient Representative Group
British Healthcare Trades Association (BHTA)	Patient Representative Group
British Limbless Ex‐Servicemen's Association (BLESMA)	Patient Representative Group
British Polio Fellowship	Patient Representative Group
British Society of Rehabilitation Medicine (BSRM)	Patient Representative Group
Chronic Pain Policy Coalition	Patient Representative Group
Circulation Foundation (Vascular Society)	Patient Representative Group
Contact A Family	Patient Representative Group
International Society of Prosthetics and Orthotics (ISPO UK)	Patient Representative Group
Limbless Association	Patient Representative Group
Meningitis Trust	Patient Representative Group
Murray Foundation	Patient Representative Group
Muscular Dystrophy Campaign	Patient Representative Group
National Wheelchair Managers Forum	Patient Representative Group
British Pain Society	Patient Representative Group
Prosthetics, Orthotics & Rehabilitation Technology–Education & Research (PORT‐ER)	Patient Representative Group
Specialised Healthcare Alliance	Patient Representative Group
Spinal Injuries Association	Patient Representative Group
Thalidomide Society	Patient Representative Group
Lindsay Leg Club Foundation	Patient Representative Group

Appendix B: 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
  - 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 SO

Appendix C: General Data on Respondents

Summary of consultation responses - physiotherapists

Table 6: Respondents' profession

Option	Total	%
Physiotherapist	511	74%
Podiatrist	12	2%
Other Allied Health Professional	21	3%
Doctor	17	2%
Nurse/Health Visitor	23	3%
Pharmacist	17	2%
Optometrist	1	0%
Midwife	0	0%
Other Health and Social Care Professional (please specify below)	20	3%
Not Answered	67	10%
Total	689	100%

Table 7: Respondents' prescribing qualifications

Option	Total	%
supplementary prescriber	67	10%
independent prescriber	37	5%
non prescriber	489	71%
Not Answered	96	14%
Total	689	100%

Table 8: Respondents' interest (Are you responding as…)

Option	Total	%
as a patient	9	1%
as a carer	2	0%
as a member of the public	11	2%
as a health or social care professional	559	81%
on behalf of an organisation	77	11%
Not Answered	31	4%
Total	689	100%

Table 9: Respondents' country

Option	Total	%
England	485	70%
Scotland	30	4%
Wales	31	5%
Northern Ireland	9	1%
Other	6	1%
Not Answered	128	19%
Total	689	100%

Appendix D: List of Organisation Responses by Group

Legend	
Q.1 Independent Prescribing by physiotherapists	
Option 1	IP for any condition from a full formulary
Option 2	IP for specified conditions from a specified formulary
Option 3	IP for any condition from a specified formulary
Option 4	IP for any condition from a specified formulary
Option 5	No change
Q. 2 Controlled Drugs Do you agree to use of a limited list of controlled drugs	
Q. 3 Mixing of Medicines Do you agree to mixing of medicines by physiotherapists	
Yes	
No	
Partly	
Neither	(Neither agree nor disagree)

Group 1: National Medical/Nursing/Pharmacy bodies and regulators

Organisation	Q.1 Independent Prescribing	Q. 2 Controlled Drugs	Q. 3 Mixing Medicines
Accountable Officers Scotland - Working Group	Option 3	Yes	Yes
British Medical Association (BMA)	Option 2	Partly	Partly
Care Quality Commission	Option 1	Yes	Yes
College of Optometrists	Option 1	Neither A nor D	Neither A nor D
Health and Social Care Board, Northern Ireland	Option 2	Partly	No
Health Professions Council	Option 1	Neither A nor D	Neither A nor D
Nursing and Midwifery Council	Option 1	Yes	Yes
Public Health Agency (Northern Ireland)	Option 1	Yes	Yes
Royal College of Anaesthetists	Option 1	Yes	Yes
Royal College of General Practitioners	Option 2	Partly	Partly
Royal College of General Practitioners Wales	Option 2	Partly	Yes
Royal College of Physicians of Edinburgh	Option 2	Partly	Yes

Group 2: AHP representative/advisory bodies

Organisation	Q.1 Independent Prescribing	Q. 2 Controlled Drugs	Q. 3 Mixing Medicines
Allied Health Professions Federation	Option 1	Yes	Yes
Allied Health Professions Professional Advisory Board	Option 1	Yes	Yes
British and Irish Orthoptic Society	Option 1	Yes	Yes
British Association of Art Therapists	Option 2	Yes	Yes
British Dietetic Association	Option 1	Yes	Yes
British Osteopathic Association	Option 2	Yes	Yes
Chartered Society of Physiotherapy	Option 1	Yes	Yes
CSP Wales Office	Option 1	Yes	Yes
Institute of Chiropodists and Podiatrists	Option 1	Yes	Yes
National AHP Patients Forum	Option 1	Yes	Yes
Society and College of Radiographers	Option 1	Yes	Yes

Group 3: Educational bodies/establishments

Organisation	Q.1 Independent Prescribing	Q. 2 Controlled Drugs	Q. 3 Mixing Medicines
Council of Deans of Health	Option 1	Yes	Yes
Health, Ethics and Law network, University of Southampton.	Option 1	Yes	Yes
NHS Education for Scotland: AHP Team & Physiotherapy Education Advisory Group	Option 1	Yes	Yes
Robert Gordon University	Option 1	Yes	Yes
Teesside University	Option 1	Yes	Yes

Group 4: Service Providers

Organisation	Q.1 Independent Prescribing	Q. 2 Controlled Drugs	Q. 3 Mixing Medicines
AGILE: Chartered physiotherapists working with older people	Option 1	Yes	Yes
AHP Directors (Scotland) Group	Option 1	Yes	Yes
All Wales Physiotherapy Managers Committee	Option 1	Yes	Yes
Aneurin Bevan Health Board	Option 1	Yes	Yes
Betsi Cadwaldr University Health Board	Option 2	Yes	Yes
Birmingham Community Health Care NHS Trust	Option 1	Yes	Yes
Bridgewater Community Healthcare NHS Trust (Halton and St Helens Division)	Option 1	Yes	Yes
Bromley Healthcare Community Interest Company Ltd.	Option 1	Yes	Yes
Cambridgeshire Community Services NHS Trust	Option 1	Yes	Yes
Cardiff and Vale University Health Board	Option 1	Yes	Yes
Central Essex Community Services	Option 2	Partly	Yes
Central London Community Healthcare NHS Trust	Option 1	Yes	Yes
Central Manchester University Hospitals NHS Foundation Trust	Option 1	Partly	Yes
Community Health Services	Option 1	Yes	Yes
Consortium of Local Medical Committees for Lancashire & Cumbria	Option 5	No	No
Derby Hospitals NHS Foundation Trust	Option 1	Yes	Yes
Derbyshire community health services NHS Trust	Option 1	Yes	Yes
Derbyshire County PCT on behalf of NDCCG, HPCCG and HHCCG	Option 2	Partly	Yes
East Sussex Healthcare Trust	Option 1	Yes	Neither A nor D
Heart of England NHS FT	Option 1	Yes	Neither A nor D
Kent Community Health NHS Trust	Option 2	Partly	Partly
Leaders and Managers of Physiotherapy Services	Option 1	Yes	Yes
Maidstone and Tunbridge Wells NHS Trust	Option 1	Partly	Yes
Napp Pharmaceuticals Ltd	Option 2	Yes	Yes
NE SHA AHP Collaborative	Option 1	Yes	Yes
NHS Cumbria/Cumbria Partnership NHS Foundation Trust	Option 1	Partly	Yes
NHS Grampian; Non-medical Prescribing Working Group	Option 1	Yes	Yes
NHS Grampian; Physiotherapy	Option 1	Yes	Yes
NHS Greater Glasgow and Clyde	Option 1	Yes	Yes
NHS Hampshire	Option 2	Yes	Yes
NHS Hertfordshire	Option 1	Partly	Partly
nmprescribing (independent non-medical prescribing	Option 1	Yes	Partly

Organisation	Q.1 Independent Prescribing	Q. 2 Controlled Drugs	Q. 3 Mixing Medicines
advisor to health care orgs)			
Norfolk and Waveney Local Medical Committee	Option 2	Partly	Partly
Norfolk Community Health and Care	Option 4	No	Yes
North West AHP Non Medical Prescribing Network.	Option 1	Yes	Yes
Oxleas NHS Foundation Trust	Option 1	Yes	Yes
Pennine Acute Trust Chronic Pain Service	Option 1	Yes	Yes
Physiotherapy Services Network, South Yorkshire and East Midlands	Option 1	Yes	Yes
Powys Teaching Health Board	Option 1	Yes	Yes
Royal Devon & Exeter NHS Foundation Trust.	Option 4	Yes	Yes
Sandwell MSK & COS Physiotherapy Service	Option 1	Yes	Yes
Somerset Partnership NHS Foundation Trust	Option 2	Neither A nor D	Partly
Sussex Community NHS Trust	Option 1	Yes	Yes
The Thalidomide Society	Option 2	Yes	Yes