

<p>Title:</p> <p><b>PROPOSALS TO INTRODUCE INDEPENDENT PRESCRIBING BY PHYSIOTHERAPISTS</b></p> <p>IA No: 1018</p> <p>Lead department or agency:</p> <p><b>Department of Health</b></p> <p>Other departments or agencies:</p> <p>MHRA</p> <p>Commission on Human Medicines</p>	<p><b>Impact Assessment (IA)</b></p>
	Date: 05/07/2012
	Stage: Final
	Source of intervention: Domestic
	Type of measure: Other
<b>Summary: Intervention and Options</b>	<b>RPC Opinion:</b>

Cost of Preferred (or more likely) Option			
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, Measure qualifies as One-Out?
£5.5m	£0m	£0m	

**What is the problem under consideration? Why is government intervention necessary?**

Current regulations do not permit physiotherapists to independently prescribe medicines. Physiotherapists are currently allowed to be supplementary prescribers. This has been shown to exhibit inefficiencies in delivery and requires unnecessary activity for doctors. There is scope to substantially increase flexibility and access of care for patients with the introduction of independent prescribing for physiotherapists. Being able to independently prescribe may improve all three domains of quality of care: safety, patient experience and effectiveness, by liberating physiotherapists to maximise the benefit they have to offer patient care.

**What are the policy objectives and the intended effects?**

Extending independent prescribing (IP) to physiotherapists is in accordance with the provisions of the Coalition Agreement and the QIPP agenda to empower health professionals to deliver appropriate and timely care to patients. Extending IP responsibilities is about making the best use of professional skills and supports the promotion of health and wellbeing within all clinical interventions, and can facilitate partnership working by improving the transition from acute to community care. Benefits include; improving the patient's treatment and experience, reducing the risk of an acute condition becoming a long term condition, reducing the care pathway, reducing requirements on GPs, and reducing A&E admissions and follow up treatments.

**What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)**

Option 1 - Independent prescribing for any condition from a full formulary  
 Option 2 - Independent prescribing for specified conditions from a specified formulary  
 Option 3 - Independent prescribing for any condition from a specified formulary  
 Option 4 - Independent prescribing for specified conditions from a full formulary  
 Option 5 - Do nothing / No change  
 The preferred option is option 1.

**Will the policy be reviewed? It be reviewed. If applicable, set review date: /**

Does implementation go beyond minimum EU requirements?					
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	Micro	< 20	Small	Medium	Large
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)	Traded:		Non-traded:		
	0		0		

**I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.**

Signed by the responsible Minister : \_\_\_\_\_ Date: 11th September 2012

# Summary: Analysis & Evidence

# Policy Option 1

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

## FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year 2012	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £38.9m	High: £209.9m	Best Estimate: £124.4

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	£0m	£0.55m	£5.48m

### Description and scale of key monetised costs by 'main affected groups'

The monetised cost is the cost of the educational programmes preparing physiotherapists to prescribe independently. This includes conversion courses required to move from supplementary prescribing to independent prescribing or full independent prescribing programmes undertaken by those who currently have no prescribing qualifications. Only physiotherapists who decide to undertake the educational programme, which is taken on a voluntary basis, will incur this cost

### Other key non-monetised costs by 'main affected groups'

- time commitment from physiotherapists to attend educational programmes
- complexities of governance of the professions

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	£4.44m	£44.43m
High	Optional	£21.54m	£215.43m
Best Estimate	£0m	£12.99m	£129.93m

### Description and scale of key monetised benefits by 'main affected groups'

- health benefit from timely treatment, reducing risk of acute conditions becoming long-term conditions (LTC)
- reduction in GP requirements in terms of time required to prescribe medicines
- reduced patient's time away from work to attend GP practice for prescription
- health benefit to patient from reduced prescriptions and improved medicine adherence

### Other key non-monetised benefits by 'main affected groups'

- improved patient care and safety thereby reducing A&E admissions
- improved access to healthcare for all, especially in rural settings and the elderly
- overcomes barriers for supplementary prescribers, e.g. clinical management plans in short-term conditions
- potential increase in self-referral to physiotherapists, reducing patient care pathway further

### Key assumptions/sensitivities/risks

Discount rate (%) 3.5

- keeping control of where information on prescribed medicines has been noted as it currently requires faith in the patient's ability to accurately recall / be honest about prescriptions previously received elsewhere
- misuse of medicines
- governance of physiotherapists

## BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: £0	Benefits: £0	Net: £0		

# Evidence Base (for summary sheets)

## Background

In 2009 recommendations were made in the *Allied health professions prescribing and medicines supply mechanisms scoping project report* to do further work to take forward independent prescribing for physiotherapists. This project provided evidence that extension of prescribing and medicines supply for certain of the allied health professions would:

- improve the patient experience by allowing patients greater access, convenience and choice
- improve patient safety
- potentially save money
- empower clinicians
- support local commissioning of innovation in service delivery.

As a result of these recommendations an engagement exercise was held between 3 September – 26 November 2010 to provide background information and seek views on the possible changes to medicines legislation that would enable appropriately trained physiotherapists to prescribe independently. The response to the engagement exercise was overwhelmingly positive. There were 190 responses with 91% supporting independent prescribing for physiotherapists.

In recent years independent prescribing responsibilities have been extended to Nurse Independent Prescribers, Pharmacist Independent Prescribers and Optometrist Independent Prescribers. The recent evaluation of nurse and pharmacist independent prescribing by the University of Southampton and Keele University<sup>1</sup> concluded that 'nurse and pharmacist independent prescribing in England is becoming a well-integrated and established means of managing a patient's condition and giving him/her access to medicines'.

Wide collaboration with stakeholders has taken place with respect to the proposals for independent prescribing for physiotherapists, including with patients, MHRA, Health Professions Council (HPC), BMA, RCN, Royal Pharmaceutical Society, National Prescribing Centre, UK Council of Deans, AHP Federation, Care Quality Commission, National Patient Safety Agency, SHA Non-Medical Prescribing Leads and the professional body, the Chartered Society of Physiotherapy (CSP). In addition, as part of the engagement exercise the Chief Health Professions Officer met with a number of key stakeholders including the Royal College of General Practitioners, BMA, NHS Alliance and the National Association of Primary Care who have all expressed support in principle for the proposals.

The CSP has undertaken significant work and has prepared practice guidance for their members who have independent prescribing responsibilities. Eligibility criteria for entrants on to the educational programme have been developed:

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

The Allied Health Professions Federation (AHPF) own the Outline Curricula Framework and will post a link to the documents on their website once they have been published.

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<sup>1</sup> Department of Health (2011), *Evaluation of nurse and pharmacist independent prescribing*, London

## Policy context

In England, the key themes in the white paper *Equity and Excellence: Liberating the NHS*<sup>2</sup>, put patients and the public first, prioritised improving healthcare outcomes, autonomy, accountability, efficiency and democratic legitimacy and cutting bureaucracy. It aimed to ensure that patients are at the centre of all decisions in the commissioning and provision of healthcare, enabling a healthcare service that means patients and the public are treated equitably when accessing healthcare services with increased access to professional skills and timely treatment. The white paper made it clear that ‘quality’ will be delivered by focusing on outcomes, giving real power to patients and devolving power and accountability by liberating frontline healthcare staff to maximise the benefit they can offer to patients.

This built on the previous work strategy outlined in *Next Stage Review final report. High Quality care for all*<sup>3</sup> created a vision for a health service in which frontline staff are empowered to lead change that will improve the effectiveness of patient care and experience. *The NHS Next Stage Review: Our Vision for primary and community care*<sup>4</sup> promoted collaboration across traditional boundaries to provide care closer to home in addition to empowering patients to make their own choices about their health and healthcare. *A High Quality Workforce: NHS Next Stage Review*<sup>5</sup> endorsed an increasingly flexible, responsive and patient focused workforce and *Framing the contribution of Allied Health Professionals: Delivering High Quality Healthcare*<sup>6</sup> highlighted the role of AHPs as first contact practitioners performing assessment, diagnosis, treatment and discharge, from primary prevention through to specialised disease management and rehabilitation.

The government is committed to putting patients and the public at the heart of everything we do. Introducing independent prescribing for physiotherapists liberates the clinician and enables them to maximise their ability to improve the patients’ care, experience and safety whilst being more cost-effective than current regulations allow.

The following relate to Northern Ireland, Department of Health Social Services and Public Safety (DHSSPS):

*A Healthier Future, a Twenty Year Vision for Health and Well-being in Northern Ireland, 2005 – 2025, DHSSPS 2004*

<http://www.dhsspsni.gov.uk/healthyfuture-main.pdf>

*A Workforce Learning Strategy for the Northern Ireland Health and Social Care Services 2009-2014, DHSSPS April 2009*

<http://www.dhsspsni.gov.uk/workforce-learning-strategy-apr-2009.pdf>

*Quality 2020 – A 10 Year Quality Strategy for Health and Social Care in Northern Ireland, DHSSPS 2011*

<http://www.dhsspsni.gov.uk/quality2020.pdf>

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<sup>2</sup> Department of Health (2010) *Equity and Excellence: Liberating the NHS*, London  
[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_117353](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353)

<sup>3</sup> Department of Health (2008) *High quality care for all: NHS Next Stage Review final report*, London  
[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085825](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825)

<sup>4</sup> Department of Health (2008) *NHS Next Stage Review: Our vision for primary and community care*, London  
[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085937](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085937)

<sup>5</sup> Department of Health (2008) *A high quality workforce: NHS Next Stage Review*, London  
[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085840](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085840)

<sup>6</sup> Department of Health (2008) *Framing the contribution of allied health professionals: Delivering high-quality healthcare*, London  
[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_089513](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089513)

*Improving Health and Well-being Through Positive Partnerships, A Strategy for the Allied Health Professions in Northern Ireland 2012-2017*, 2012, DHSSPS Belfast

[www.dhsspsni.gov.uk/ahp-strategy-feb-2012.pdf](http://www.dhsspsni.gov.uk/ahp-strategy-feb-2012.pdf)

*Transforming your care – A Review of Health and Social Care in Northern Ireland*, 2011, DHSSPS Belfast

<http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf>

The following relates to Scotland:

*AHPs as agents of change in health and social care – The National Delivery Plan for the Allied Health Professions in Scotland, 2012 – 2015*, The Scottish Government, Edinburgh (2012)

<http://www.scotland.gov.uk/Publications/2012/06/9095/0>

The following relate to Wales:

Welsh Government( 2011). Together for Health A Fiver Year Vision for the NHS in Wales. Welsh Government

<http://wales.gov.uk/topics/health/publications/health/reports/together/?lang=en>

Welsh Government ( 2012) Achieving Excellence. The Quality Delivery Plan for the NHS in Wales 2012-2016. Welsh Government

<http://wales.gov.uk/topics/health/publications/health/strategies/excellence/?lang=en>

Welsh Government ( 2012) Working Differently - Working Together. A Workforce and Organisational development framework. Welsh Government

<http://wales.gov.uk/topics/health/publications/health/strategies/working/?lang=en>

### **Rationale for intervention**

Current legislation permits physiotherapists to become supplementary prescribers of medicines. There is scope to substantially increase the benefit that physiotherapists offer the patient in terms of their quality of care, safety, patient experience and effectiveness by allowing them to independently prescribe medicines. Independent prescribing would allow physiotherapists to provide more accessible and effective care for the patient, it would reduce the patient's care pathway as they would no longer require a follow up appointment with a GP in order to access a prescription and would maximise the capabilities the physiotherapist has to offer. Independent prescribing liberates the clinician and maximises their ability to improve patient care in a more cost effective way than current regulations allow. An engagement exercise was held in 2010, which showed 91% support for introducing independent prescribing. As a point of comparison, the 2% of responses that favoured no change did not include any organisations, only responses on behalf of individuals. 7% of respondents expressed no view.

### **Policy objective**

The objective of introducing independent prescribing for physiotherapists is to enhance patient care by improving access to medicines through an increased and more flexible approach. In turn, implementation will address the three domains of quality: safety, patient experience and effectiveness. It is important to recognise and state that if policy and legislative changes occur in the future. It is not anticipated that all physiotherapists would become independent prescribers. Only those clinicians who are already working at a highly skilled and specialist level, in a relevant clinical/service area will progress to independent prescribing. This is not about individual career development, it is about improving patient care/access to medicines through service re-design/delivery and must not compromise patient safety at any point. Physiotherapists who have completed the relevant post registration training, may currently

prescribe as supplementary prescribers and the progression to independent prescribers' status is an addition to that responsibility.

### Patient safety

Medicines legislation underpins the safe and effective use of medicines. In some clinical pathways, the scope of the existing legislation fits well with the needs of patients and enables optimal care. In other pathways the existing legislation limits the delivery of optimal care, which in turn has the potential to impact upon patient safety.

Allied health professionals are involved in medicines safety committees and non-medical prescribing clinical support networks. For example, NHS North West has a well-established network for promoting the safe and effective use of non-medical prescribing, including a designated AHP lead. No serious incidents or case law relating to AHP medicines use have been reported to date. The AHP prescribing and medicines supply mechanism scoping project (2009) identified that 'no significant concerns have been identified regarding the potential advancement of prescribing and medicines supply for specific AHPs.

Currently, avoidable delays in patient care occur when a physiotherapist could safely prescribe or supply a medicine, but is unable to do so under the existing arrangements. Delayed care can impact negatively upon a patient's experience, reduce treatment effectiveness and potentially place patients at risk. Introducing independent prescribing by physiotherapists could enable certain specialist staff in key areas to deliver the prompt care that is needed, thereby avoiding safety risks and the costs of delaying care.

Timely administration of appropriate antibiotics has been shown to reduce hospital admissions and the risk of limb-threatening infection in people with diabetes.<sup>7</sup> The existing arrangements for community physiotherapists using PGDs and Exemptions do not cover all circumstances, and timely supplementary prescribing is not always possible in the community because a doctor may not be available to agree the clinical management plan.

Many physiotherapists work in specialist clinical areas and could make timely reductions in analgesic preparation and/or dose as a patient responds to physical treatment, thereby reducing the risk of dependency. Similarly, non-steroidal anti-inflammatory drugs, which have documented gastrointestinal and cardiovascular risks,<sup>8</sup> can be reduced as a patient responds to physical intervention and self-management.

### Patient experience

Physiotherapy offers many innovative services, improving access, choice and convenience. Some examples include physiotherapy self-referral schemes, and combined multi-disciplinary therapy teams supporting patients at home to prevent emergency admission to hospital.

Some of these innovative services make use of the existing mechanisms to provide patients with greater access to medicines. However, there is potential for some of these services to further improve access and thereby empower patients to make their own choices about health and healthcare. For example, a patient with back pain may appropriately consider self-referring to physiotherapy, but if they perceive a need for a medicine they must see their GP, independent nurse prescriber or pharmacist prescriber instead of, or in addition to, the physiotherapist. The introduction of independent prescribing by physiotherapy services could avoid the inconvenience for patients of multiple appointments with associated duplication of travel, parking and time off work. Furthermore, streamlining patient care in this way could

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<sup>7</sup> Lipsky B., Berendt A. and Deery, H. et al. (2004), ISDA Guideline: Diagnosing and treating diabetic foot infections, *Clinical Infectious Diseases*, 39, 885-910

<sup>8</sup> Duff, G. (2006) *Safety of selective and non-selective NSAIDs*. Commission of Human Medicines, Medicines and Healthcare products Regulatory Agency. Urgent correspondence to all NHS trusts, 24 October 2006

improve patient access to new prescriptions and offer accessible advice regarding dose alteration and concordance with existing medicines for patients of certain existing AHP services. Patients often access these services between visits to their GP or hospital doctor and the potential to reduce inefficiencies and avoidable appointments would facilitate an infrastructure that enables frontline staff to lead change for patient benefit, providing comprehensive care closer to home and facilitating greater outreach of hospital and primary care services. For example, extending access to medicines among traditionally hard-to-reach and rural populations through enhanced services has the potential to improve access as well as reducing health inequalities. Elderly, disabled, traveller and ethnic minority groups are likely to benefit from enhanced, more accessible and responsive services being offered from a variety of locations, closer to home.

### Effectiveness

Effectiveness refers to the outcomes of clinical care, avoidance of ill health and helping people to stay healthy. Under the present arrangements, the extent to which the implementation of non-medical prescribing promotes effective care varies according to the clinical pathway. In some cases, the existing mechanisms enable highly effective care.

However, in many cases the existing mechanisms do not allow optimal effectiveness. For example, the PSD requires the doctor to be available to write a prescription and if necessary have the opportunity to review and/or examine the patient prior to prescribing. Many MSK clinic services are physiotherapy-led with no doctor present. A PGD does not allow medicines to be mixed prior to administration and supplementary prescribing is not suitable for many MSK type services which act as 'one-stop-shops' for patients with short-lived, short term conditions, or conditions that do not require frequent review. PGDs are not normally appropriate due to the breadth of possible medicines required. Supplementary prescribing is not suited to one-off episodes of care, particularly as the physiotherapist is assessing, diagnosing and treating the patient. Consequently, the supplementary prescriber must take alternative and potentially costly action, such as an A&E referral.

In numerous clinical pathways, physiotherapists now deliver care that was previously provided by doctors, or work collaboratively across traditional boundaries. Physiotherapists see self-referred patients, independently manage orthopaedic and rheumatology referrals in musculoskeletal assessment and treatment services, and lead outpatient review clinics and/or community services in neurology, women's health and respiratory care. In these clinical pathways, investigations, diagnostic and/or therapeutic procedures and appropriate onward referral can occur as it would in medically led care. Physiotherapists deliver high-quality care but this is often in the absence of optimal medicines management. Consequently the service provided by the allied health professional is less comprehensive and therefore less effective than it could be. A lack of access to appropriate prescribing or medicines supply mechanisms also means that innovative care pathways may not be developed at all.

A physiotherapist is often the multidisciplinary team member with whom the patient spends the most time. Appointments may last 30 to 60 minutes or longer, on multiple days over multiple weeks. This allows considerable opportunity for discussion of shared outcomes with a patient, improving adherence and patient safety. This can enhance the safe and effective use of medicines<sup>9</sup>, potentially reducing waste and improving outcomes for patients with existing disease. It also has the potential to help improve health and well-being through better long-term use of medicines.

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<sup>9</sup> National Institute of Health and Clinical Excellence, 2009, NICE Guidance, Medicines Adherence, January 2009. London

Overall the introduction of independent prescribing by physiotherapists will:

- Improve the quality of service to patients/public without compromising patient safety
- Demonstrate value for money by improving patient access and choice reducing avoidable duplication and inefficiencies and streamlining service delivery
- Make it easier for patients/public to get the medicines they need
- Increase patient choice and convenience in accessing medicines
- Free up the time of doctors to conduct other clinical work
- Potentially reduce unnecessary appointments and waiting lists
- Contribute to the introduction of more flexible, collaborative team working
- Maximise the benefits of fully utilising diverse professional skills

### **Consultation and Considered Options**

An engagement exercise was held over 12 weeks between 3 September 2010 and 26 November 2010. The engagement exercise followed recommendations in the 2009 *Allied health professions prescribing and medicines supply mechanisms scoping project report*<sup>10</sup>. The response to the engagement exercise was overwhelmingly positive, with 91% support for extending independent prescribing by physiotherapists<sup>11</sup>. The exercise gathered significant information on the key issues and posed some further questions in respect of independent prescribing by physiotherapists to inform a public consultation.

### **Public consultation**

In September 2011, Ministers agreed to a public consultation on proposals for independent prescribing by physiotherapists, the mixing of medicines and a limited list of controlled drugs. The proposals specifically excluded the independent prescribing of unlicensed medicines following consideration of feedback from the engagement exercise. The consultation was held jointly by the Department of Health and the Medicines and Healthcare products Regulatory Agency (MHRA) between 15th September 2011 and 30th December 2011<sup>12</sup>.

In total, 689 responses to the consultation were received, with responses from all four countries of the UK. There were 22 responses from patients, carers or members of the public and 559 from health or social care professionals including: doctors, nurses, pharmacists and AHPs. Responses were received on behalf of 78 organisations.

The responses to the consultation show very strong support for introducing independent prescribing for physiotherapists, with only 9 of the 689 responses (1%) preferring 'no change'. The remainder of respondents opted for independent prescribing in some form. Option 1, independent prescribing for any condition from a full formulary, was the preferred option for 64% of all respondents. The remaining 35% preferred one of the other options, with a limited formulary, limited conditions or both.

The flexibility offered by Option 1, independent prescribing for any condition from a full formulary, was a major theme in the comments received in response to the consultation. Respondents often stressed that this is only within the practitioner's scope of practice and competence. Some comments refer to the impracticalities of a specified formulary and a limited list of conditions at legislative level. A number of comments reflected the need for and ability to provide good governance and safe prescribing with this option. Benefits identified by

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<sup>10</sup> Department of Health (2009), *Allied health professions prescribing and medicines supply mechanisms scoping project report*, London [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_103948](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103948)

<sup>11</sup> Department of Health (2010), *Engagement exercise to seek views on possibilities for introducing independent prescribing responsibilities for physiotherapists and podiatrists*, London [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_119164](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119164)

<sup>12</sup> Department of Health (2011), *Proposals to introduce independent prescribing by physiotherapists*, [http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH\\_129983](http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_129983)



respondents included the opportunity to redesign services and improve patient access to medicines.

In relation to option 2, independent prescribing for specified conditions from a specified formulary, some comments reflected the need for physiotherapists to work within their scope of practice and competence. The need to provide good communication of their prescribing to GPs and other relevant clinicians to ensure patient safety was also highlighted. Concerns about the knowledge of clinical pharmacology and examination and assessment skills were also reasons for some respondents preferring option 2. 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.

The summary of responses to the consultation, that this impact assessment is published alongside, provides a more detailed analysis of themes emerging from responses to the consultation.

### **One-in one-out**

The Government introduced the one-in one-out (OIOO) rule in order to reduce the cost and volume of regulations impacting small businesses and civil society organisations. It requires, for any new primary legislation looking to be introduced, an equal to be identified to be removed. The scope of OIOO includes any new primary regulation that has a direct annual net cost on business or civil society organisations.

The proposal for the introduction of independent prescribing by physiotherapists does not fall under OIOO as it is a voluntary option for the profession and it's main target audience are physiotherapists working in the NHS. Although physiotherapists in the private sector will voluntarily be able to also take on independent prescribing, should they meet the entry criteria, it is an indirect impact rather than direct. The proposals would not require a change in primary legislation, which OIOO targets. In addition, the introduction of independent prescribing for full formulary and all conditions would support innovation within healthcare.

### **Specific Impact Tests**

*Assessment of Impact on Equality:* An AIE has been undertaken as part of this impact assessment and evidence has been collected throughout the public consultation via engagement with the public. The proposals do not result in any change in access to services as compared to the current situation.

*Economic Impacts:* The impact of the proposals on small firms and competition is discussed in the 'Wider impacts' section, below (pages 27 and 31 respectively). There is no expected impact on small firms given that the proposals are targeted at NHS physiotherapists. The policy does not bring into play the micro-business exemption rule as independent prescribing is to be taken up on a voluntary basis.

*Environmental Impacts:* A greenhouse gas assessment has not be undertaken for this policy as it is not expected to have any impact on greenhouse gas emissions, energy use or CO2 changes. Similarly there is no expected impact on wider environmental issues as the policy affects prescribing qualifications of physiotherapists, which does not have any environmental considerations.

*Social Impacts:* The impact on health and well-being is discussed within this impact assessment, under the 'Wider impacts' section. With regards to the impact on human rights, no human rights articles will be impinged as a result of the policy and hence no human rights impact assessment was undertaken. Likewise the policy will not affect the workings of the

courts, tribunals, prisons, the legal aid budget or the prosecuting bodies and judiciary. No justice impact assessment was undertaken because of this. The policy will make independent prescribing an option for those who meet the eligibility criteria, whether they be in a rural or urban setting. Given that physiotherapists are practising throughout England there is no bias in its implementation and hence no rural proofing impact test undertaken.

*Sustainable Development:* The proposals will not infringe upon the position of future generations and hence a sustainable development impact assessment has not been done.

### **Risk Assessment**

It is standard practice for an impact assessment to consider the risks of any proposed change, and we therefore need to explore whether any risks arise from granting independent prescribing to physiotherapists.

The extent to which independent prescribing is adopted and implemented within is a matter for each provider. Subject to policy and legislative changes, the decision to implement independent prescribing by physiotherapists is voluntary and will be dependent on population need, specialist clinical area and local commissioning arrangements.

Services that implement non-medical prescribing must identify a role that requires a physiotherapist to gain entry to and pass an approved non-medical prescribing training programme. To be eligible for the programme they must already be highly advanced or expert in their clinical field and their employer organisation must have identified a suitable role for them to undertake once they have completed the training. Non-medical prescribing educational programmes are multi-professional in nature and allow several professionals to share access to a common educational provider whilst the learning outcomes are sensitive to the different legislative framework applied to each profession. The introduction of independent prescribing by physiotherapists will require suitably qualified supplementary prescribers accessing and successfully completing a conversion programme. However, subsequently 'new' entrants into prescribing training will be trained as independent/supplementary prescribers from the outset and so the requirements for a conversion educational programme will be time limited.

Physiotherapists may currently prescribe as supplementary prescribers and the progression to independent prescriber status is an addition to that responsibility. Enabling physiotherapists to prescribe any licensed medicine for any condition subject to clinical competence will not be at the expense of endangering public health. Physiotherapists will only be able to practise as independent prescribers once they have successfully completed the relevant educational programmes and have their registration annotated by their regulatory body. In order to maintain annotation physiotherapist independent prescribers will need to demonstrate that they maintain their skills and knowledge in line with practice and only work within their areas of competence.

### **Enforcement and sanctions**

The proposals will be implemented through amendments to the Human Medicines Regulations 2012. Among other matters, the Regulations set out the legal provisions for prescribing, sale supply and administration of medicines. Sanction will apply where an organisation/individual failed to operate within medicines legislation or within proper professional conduct. The Medicines and Healthcare products Regulatory Agency (MHRA) is responsible for enforcing medicines legislation on behalf of the Secretary of State. The Health Professions Council is responsible for matters of professional regulation for physiotherapists.

## Background information for costs and benefits of independent prescribing for physiotherapy

### Physiotherapists

There are 46,689 physiotherapists in the UK registered with the Health Professions Council (HPC)<sup>13</sup>. The CSP has 37,219 physiotherapists in the UK registered as ‘full-practising’ members as of May 2011<sup>14</sup>, of which the HPC has a count of 204 as supplementary prescribers<sup>15</sup>.

### Physiotherapy patients requiring a prescription

It is estimated that 33% of patients who visit a physiotherapist for the first time each year require a prescription<sup>16</sup>. This results in an estimated 269,468 physiotherapy patients requiring a prescription in 2010.

### Supply of independent prescribing educational programmes available to physiotherapists

Physiotherapists are currently able to train as supplementary prescribers at the following 55 Higher Education Institutions (HEIs) in the UK, which run HPC approved programmes<sup>17</sup>.

<b>England:</b>	St George's University of London	University of the West of England, Bristol
Anglia Ruskin University	Staffordshire University	University of Wolverhampton
Birmingham City University	Suffolk, University Campus	University of Worcester
Bournemouth University	Teesside University	University of York
Canterbury Christ Church University	The University of Bolton	<b>Northern Ireland:</b>
City University	University of Bradford	University of Ulster
Coventry University	University of Brighton	<b>Scotland:</b>
De Montfort University	University of Central Lancashire	Edinburgh Napier University
Edge Hill University	University of Chester	Glasgow Caledonian University
HSHS Ltd	University of Cumbria	Queen Margaret University
Keele University	University of Derby	The Robert Gordon University
Leeds Metropolitan University	University of Essex	University of Dundee
Liverpool John Moores University	University of Hertfordshire	University of Stirling
London Metropolitan University	University of Huddersfield	University of the West of Scotland
London South Bank University	University of Hull	<b>Wales:</b>
Manchester Metropolitan University	University of Lincoln	Cardiff University (Prifysgol Caerdydd)
Medway School of Pharmacy	University of Nottingham	Glyndwr University
Northumbria University at Newcastle	University of Plymouth	Swansea University
Oxford Brookes University	University of Salford	University of Glamorgan
Sheffield Hallam University	University of Southampton	

The University of Bolton, Leeds Metropolitan University and City University offer multi-professional programmes with 100, 50 and 40-60 places respectively per year. It can be assumed that supplementary prescribing programmes will progress to offer full independent prescribing programmes for physiotherapists in line with the changes in the profession's regulations. It is assumed that conversion programmes will be phased out after year 2. Full independent prescribing training courses are of duration 6 months. Should the proposals be implemented, physiotherapists would be able to undertake full independent prescribing training from autumn 2013. The benefits as a result of the full training programme will therefore not be realised until the financial year 2014-15, and this is reflected in the calculations.

These courses are multi-professional and therefore are attended by nurses, pharmacists, podiatrists and physiotherapists. Given that physiotherapy is 1/10<sup>th</sup> the size of nursing it is a moderate assumption that, at best, physiotherapists will take up 8% of places on these multi-professional courses. However, if greater demand for training exists amongst physiotherapists, they will be able to take up a higher proportion of places; there is no restriction on this. It is

<sup>13</sup> Health Professions Council, *FR01480 Registration statistics* 1 February 2012, <http://www.hpc-uk.org/publications/foi/index.asp?id=531>

<sup>14</sup> Sourced through correspondence with the CSP

<sup>15</sup> Health Professions Council, *FR01341, Number of supplementary prescribers*, 20 September 2011, <http://www.hpc-uk.org/publications/foi/index.asp?id=500>

<sup>16</sup> Department of Health (2008), *Self-referral pilots to musculoskeletal physiotherapy and the implication for improving access to other AHP services*, London [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_089516](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089516)

<sup>17</sup> Health Professions Council, Register of approved programmes [www.hpc-uk.org/education/programmes/register](http://www.hpc-uk.org/education/programmes/register)

assumed that demand will be high for the first 5 years and that 8% of places will be filled by physiotherapists during this period.

Given the estimated high demand for independent prescribing educational programmes it can be assumed that provision of the programmes will increase. It has been estimated that this will be an increase of 10% in years 2, 3 and 4. This increase is expected to be by existing training providers offering additional cohorts rather than new education providers that have not offered these courses before.

In addition to the costs of the actual course, the training programmes for independent prescribing involve a period of learning in practice, where the physiotherapist will require mentoring by a Designated Medical Practitioner (DMP). Under current arrangements, it is not normal practice for a DMP to charge for their time. The time commitment is seen as part of service redesign and will ultimately result in a time saving to the DMP, once the newly trained independent prescriber no longer requires supervision. The DMP will also benefit from carrying out this rewarding role as it will contribute to their own Continuing Professional Development. However, the DMP does need to make an initial time commitment in order for the independent prescriber to complete their training. Therefore, the cost of this aspect of the training is estimated as part of this impact assessment.

In order to complete the training required for independent prescribing, a physiotherapist must complete a minimum of 12 days of learning in practice. The time commitment for the DMP will vary according to local practice and to individual needs. The majority of the time will be spent in a clinical setting, with the DMP still able to carry out their usual duties, such that no 'cost' is associated with this time. Some time will be dedicated to acting solely as a DMP, for example when reviewing the training log book and progress against competencies. For the purposes of these calculations we have assumed one hour of a GP's time per day. This element of training also currently applies for those training as supplementary prescribers.

#### Demand for independent prescribing educational programmes by physiotherapists

Demand for physiotherapist independent prescribing educational programmes will depend on the demand for a physiotherapist who can independently prescribe in the geographical area, the cost of the educational programme, availability of educational programmes and availability of a designated medical practitioner to supervise the practical aspect of the programme. Based on a survey of current supplementary prescribing physiotherapists, 96% said they will pursue the educational programme to convert to independent prescribing (196 supplementary prescribers)<sup>18</sup>. We estimate that 60% of those wanting to convert will do so in year 1 and 40% in year 2. That is, 118 will demand the conversion course in year 1 and 78 in year 2. Conversion courses are thought not to exist past year 2 given that physiotherapists would no longer pursue supplementary prescribing if independent prescribing became available.

Demand for the full independent prescribing programme by those with no current prescribing qualifications is projected at 5%. This is based on the evidence that between 2% and 3% of the nursing profession have taken on independent prescribing<sup>19</sup>. The proportion is expected to be higher for physiotherapists because they come into contact with patients who would benefit from them being able to independently prescribe on a daily basis. This is largely because they work in the community setting more frequently, unlike nurses who largely work within a hospital and therefore in close proximity to an independent prescribing doctor. In addition, a sample survey of eligible podiatrists supports the assumption that 5% of all practising podiatrists will take up independent prescribing in the first 3 to 5 years. In physiotherapy, there are comparable categories of practitioners who would have equal interest in independent prescribing to those

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<sup>18</sup> Survey conducted by CSP; results obtained via correspondence.

<sup>19</sup> University of Southampton, Keele University, *Evaluation of nurse and pharmacist independent prescribing*. <http://eprints.soton.ac.uk/184777/3/ENPIPfullreport.pdf>

podiatrists surveyed. It is therefore a reasonable assumption that the 5% figure would also apply to physiotherapy.

### Projected number of physiotherapists who can independently prescribe and resulting number of appointments available with physiotherapists who can independently prescribe over the coming years

It is assumed that 5% of the existing workforce (1,851) would pursue independent prescribing over the first five years. If all were to train in this period (in addition to 5% of newly-eligible physiotherapists each year), they would take up around 20% of projected available training places. Rather than assume such a high uptake, we have assumed that physiotherapists will fill 8% of training places in years 1 to 5. In years 6 to 10, it is assumed that 5% of newly-eligible physiotherapists will train each year, there being sufficient training places to meet this level of demand. The number of newly-qualified physiotherapists is used as a proxy for the number becoming newly-eligible to undertake independent prescribing. The average number of physiotherapists registering with the HPC over the last 5 years is 4,197 per year<sup>20</sup>. Approximately 80% of all physiotherapists registered with the HPC are full-practising members. Therefore 80% of 4,197 is used as a proxy for the number of newly-eligible physiotherapists each year. This equates to 3,358. It is assumed that 5% of this figure (168) take on independent prescribing per year in years 6 to 10.

In 2010-11 there were 680,645 first new appointments with a physiotherapists in the NHS England<sup>21</sup> with 22,029 physiotherapists working in the same area<sup>22</sup>. This equates to an average of 31 new appointments per year for each NHS physiotherapist in England. This figure is assumed to apply to all physiotherapists in the UK in these calculations and is used to estimate the number of appointments that would be available with an independently prescribing physiotherapist each year.

Further background information on the potential impact of independent prescribing for physiotherapists is available from the AHP North West non-medical prescribing network audit<sup>23</sup>. This annual clinical audit demonstrates how NMP impacts on the delivery of patient care. The audit covers a number of NHS organisations across the North West region and includes consultations from several professions, including physiotherapists.

Clinicians were asked what the impact of their consultation had been. Of the 584 responses from physiotherapists and podiatrists in 2011, responses included:

- Prevention of GP surgery appointment: 154 cases (26%)
- Prevention of GP home visit: 85 cases (15%)
- Prevention of follow-up by consultant (or team) or new referral to consultant: 112 cases (19%)
- Prevention of follow up or care by another healthcare professional: 99 cases (17%)
- Prevention of absence at work or school: 30 cases (5%)
- Prevention of A&E attendance: 11 cases (2%)

Not all of the benefits listed above have been monetised as part of this impact assessment but the audit provides additional evidence of potential benefits to patients and clinicians.

<sup>20</sup> Health Professions Council, *Physiotherapists – number of registrations 2003-2012*, <http://www.hpc-uk.org/publications/foi/index.asp?id=554>

<sup>21</sup> NHS Information Centre, *Hospital Episode Statistics, Treatment Speciality Table 2010-11*  
[www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=895](http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=895)

<sup>22</sup> NHS Information Centre, *NHS Staff 2000-2010: Non-Medical Staff 2010*, [www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-2000--2010-non-medical](http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-2000--2010-non-medical)

<sup>23</sup> North West Non-medical Prescribing Audit data, 2010-2011, sourced via correspondence. Some audit details available at: <http://www.prescribingforsuccess.co.uk/ahpzone/>

For each consultation with a podiatrist or physiotherapist, the audit also asked the clinician to consider what the impact of independent prescribing status would have been on patient care, compared with supplementary prescribing. The 532 responses to this part of the audit included:

- A quicker consultation would have been possible for the patient: 148 cases (28%)
- Quicker access to medicines: 144 cases (27%)
- Would have provided a complete episode of care: 135 cases (25%)
- Fewer appointments would have been required for the patient: 90 cases (17%)
- No impact: 15 cases (3%)

The audit data demonstrate that independent prescribing for physiotherapists can result in a complete episode of care for patients, quicker access to medicines and reduced care pathways. In the 2011 audit, a review of medicines took place in 88% of consultations with a podiatrist or physiotherapist. In 13% of these cases, inappropriate medicine regimes were identified and in 16% of cases, sub-therapeutic doses were identified.

## Costs and benefits of options

### 'Do nothing' option

It is convention to include a 'do nothing' option in an impact assessment. This option is to maintain the status quo, and has costs and benefits of zero. All costs and benefits of the other options are calculated relative to this, such that if the 'do nothing' option has negative cost implications, these would be represented by a benefit for the other options. This option would involve no initiation of specific measures in terms of prescribing practices for physiotherapy patients, and therefore continuation of current prescribing practices. This would result in the continuation of the limitations of clinical practice described earlier in this impact assessment, although supplementary prescribing for physiotherapists would continue as it does currently.

### Benefits of Option 1: Independent prescribing for all conditions and full formulary

The following benefits are a result of those converting to independent prescribing from supplementary prescribing and those with no current prescribing qualifications completing the full independent prescribing educational programme.

#### a) Health benefit to patient from timely treatment, thereby reducing risk of acute conditions becoming long-term conditions (LTC) (or of an exacerbation of an existing LTC)

A moderate assumption is that receiving timely and specialist treatment from a physiotherapist who is able to independently prescribe reduces the patient's risk of their acute condition becoming a LTC (or of an exacerbation of an existing LTC) by 3%. An assumption is made because there is no evidence to what this figure is across different acute conditions. A range is therefore inserted here with a low of 1% and a high of 5%.

Clinical examples of where timely prescribing can improve health outcomes in this way include treatment of back pain, treatment of musculoskeletal injuries such as ankle injuries, pain control following surgery and treatment of acute asthma by respiratory physiotherapists.

Here a LTC is defined as a condition affecting the patient for 1 year. Benefits to the individual patient may typically last more than one year but we restrict our benefit calculation to one year as a conservative estimate.

Health benefits can be calculated using an economic evaluation method called Quality Adjusted Life Years (QALYs). A QALY is used to calculate the quality *and* quantity of life changes as a

result of a health intervention. In this case the intervention is the timely provision of prescriptions due to independently prescribing physiotherapists, which prevents acute conditions becoming LTCs (or exacerbations of existing LTCs), rather than the patient having to wait to access the prescription from their GP.

This is projected to save £1,316,880 in year 1, £4,573,951 in year 2 and £128,251,755 over 10 years (present value). Please see benefits section a) in annex 2 for calculation of these figures.

If the risk of developing a LTC was 1% rather than 3%, the saving would be £42,750,585 over 10 years (present value). If this risk was 5%, the saving would be £213,752,924 over 10 years (present value).

#### b) Reduction in GP requirements

The introduction of independent prescribing for physiotherapists would mean that patients do not need to visit a GP in order to access a prescription recommended by the physiotherapist. In some cases, patients require a GP appointment in order to access the prescription. In many cases the patient would not require an appointment, but the GP would need to spend time assessing the patient notes and issuing the prescription. As a conservative estimate, we have assumed a time saving of 5 minutes per patient that requires a prescription. The patient's pathway will therefore change from bi) to bii)

bi) GP appointment → physiotherapy appointment → attendance at GP practice (in some cases for a GP appointment)

(or if self-referral: physiotherapy appointment → GP)

bii) GP appointment → physiotherapy appointment

(or if self-referral: physiotherapy appointment)

Five minutes of a GP's time costs a GP surgery £10<sup>24</sup>. The time saved for GPs would result in an estimated financial saving to GP surgeries in the UK of £12,168 in year 1, £41,447 in year 2 and £1,056,502 over the first 10 years (present value). Please see benefits section b) in Annex 2 for the calculation of these figures. This is not expected to be cash-releasing; it will permit alternative uses of GP time.

#### c) Reduced time away from work for patient to acquire prescription

A moderate assumption for a patient's time requirement for attending a GP practice is 45 minutes, which includes travel, waiting and (in some cases) attending an appointment. The average hourly wage in the UK is £11.20<sup>25</sup>. The 45 minutes therefore costs the patient £8.40. This saving will only apply to those patients who are currently in employment. The proportion of physiotherapy patients currently in employment is estimated to be 58%<sup>26</sup>.

This is projected to save £5,881 in year 1, £20,033 in year 2 and £510,642 over the first 10 years (present value). Please see benefits section c) in annex 2 for the calculation of these figures.

There would be an additional saving to these patients in relation to travel costs for attending the GP practice; these have not been monetised in this impact assessment.

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<sup>24</sup> Personal Social Services Research Unit, *Unit Costs of Health and Social Care 2010*, II Community-based staff, 10. Nurses and doctors, <http://www.pssru.ac.uk/uc/uc2010contents.htm>

<sup>25</sup> Office for National Statistics, *Annual Survey of Hours and Earnings*, 2011 Provisional results, Table 1.5a, median earnings for all employees, <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-235202>

<sup>26</sup> Office for National Statistics, *Labour Market Statistics*, February 2012, <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-222474>

#### d) Reduced prescriptions required due to tailored treatment

Physiotherapy appointments last approximately 40 minutes compared to an average 11-minute GP appointment. This provides the patient with more time with the clinician and therefore more tailored and comprehensive treatment of their condition. There is an estimated 14% reduction in the number of required prescriptions because of this<sup>27</sup>. This will be a saving for patients who fund their own prescription charges in England, or a saving to the Government in the case of the devolved administrations and for those patients in England who are on state benefits (for whom the Government subsidises prescription charges).

Accessing a prescription in England costs the patient £7.65. In the other countries of the UK, there is no such standard prescription charge, but there is still a cost to the Government associated with each prescription. The cost per prescription item in Scotland is £10.93<sup>28</sup>, in Wales is £8.43<sup>29</sup> and in Northern Ireland is £12.23<sup>30</sup>. For these calculations the value of £7.65 is used for the whole of the UK as a conservative estimate.

The projected saving is £1,293 in year 1, £4,404 in year 2 and £112,253 over 10 years (present value). Please see benefits section d) in annex 2 for details of these calculations.

#### Non-monetised benefits

- e) improves patient care and safety by improving specialised and multidisciplinary care
- d) improves access to healthcare for all groups, such as the elderly and those in rural settings
- f) reduces A&E admissions due to more timely treatment of conditions
- g) increases respect for profession from both patients and other medical professions
- h) overcomes barriers that exist for supplementary prescribers such as the Clinical Management Plan (CMP)
- i) reduces requirements for follow-up by a consultant or other healthcare professional
- j) improves patient experience

#### Summary of Benefits

Physiotherapists being able to independently prescribe would offer patients more accessible, timely, tailored and therefore potentially more effective treatment. It would reduce the burden on GPs' time and empower physiotherapists to treat the patient in the most effective way. This ultimately improves the patient's experience of healthcare and improves their health. Please see annex 2 for the 10 year financial projection of the benefits of introducing independent prescribing for physiotherapists.

### **Costs of Option 1: Independent prescribing for all conditions and full formulary**

#### Cost of educational programmes for independent prescribing

Conversion programmes are expected to remain in place for years 1 and 2 only; if independent prescribing is introduced it is assumed physiotherapists would no longer take on supplementary prescribing as it does not offer the same benefits.

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<sup>27</sup> Department of Health (2008), *Self-referral pilots to musculoskeletal physiotherapy and the implication for improving access to other AHP services*, London [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_089516](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089516)

<sup>28</sup> ISD Scotland (NHS National Services Scotland), *Prescribing and Medicines: Prescription Cost Analysis, 2010-11*, Table 2, <http://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Publications/2011-06-28/2011-06-28-PrescribingCosts-Report.pdf>

<sup>29</sup> Welsh Government, *Prescriptions Dispensed in the Community, 2000-2010 and Prescription Cost Analysis Data*, <http://wales.gov.uk/topics/statistics/headlines/health2011/1103301/?lang=en>

<sup>30</sup> Northern Ireland, Department of Health, Social Services and Public Safety, *Counts & Cost of Prescriptions, 1990-2010*, <http://www.dhsspsni.gov.uk/pas-facts-figures>



a) Conversion programme to train from supplementary prescriber to independent prescriber  
A conversion course costs on average £600. A survey of current supplementary prescribers showed that 96% would convert to independent prescribing. It is assumed these physiotherapists will convert within the first 2 years of independent prescribing becoming available: 60% in year 1 = 118 and 40% in year 2 = 78.

Total cost of conversion courses = £116,017 (present value)

b) Full independent prescribing programme

A full independent prescribing educational programme costs on average £1,250.

Cost of full training programmes in year 1 = £275,000 (present value)

Cost of full training programmes over 10 year period = £2,353,267 (present value)

### c) Cost of supervision by Designated Medical Practitioners

These calculations do not imply a cash payment to a DMP, as payment for their services. The 'cost' is that associated with the DMP's time in terms of them being taken away from their usual duties, in order to fulfil the requirements of their DMP role. The cost calculated here is based on one hour of a GP's time per day, for 12 days:

Cost of GP's time: Cost per hour of GMS activity = £121<sup>31</sup>.

Cost per physiotherapist = 12 x £121 = £1,452

Total DMP supervision costs in year 1 = £490,776 (present value)

Total DMP supervision costs over 10 year period = £3,014,317 (present value)

### Non-monetised costs

d) time commitment required away from work for training

e) complexities of governance of the professions

It is anticipated that the cost of monitoring independent prescribing by physiotherapists will be minimal, as existing governance arrangements will include monitoring of prescribing activity.

### **Net benefit of Option 1: Independent prescribing for any condition from a full formulary**

The net benefit is calculated by subtracting the costs of the proposal from the benefits in order to see the overall financial impact.

In year 1, the benefits from the full independent prescribing courses are yet to be realised. This is because the full courses will only become available to physiotherapists partway through year 1, and the course is of duration 6 months. In year 1 there is a net projected benefit of £499,646, and this increases to a net benefit of £3,853,418 in year 2.

10 Year Period: £129,931,152 (benefit) - £5,483,601 (cost) = £124,447,551 (net present value)

Please see annex 2 for detailed projection of 10 year costs and benefits.

Net benefit with the assumption of 1% risk of an acute condition becoming a LTC:

10 Year Period: £44,429,982 (benefit) - £5,483,601 (cost) = £38,946,381 (net present value)

Net benefit with the assumption of 5% risk of an acute condition becoming a LTC:

10 Year Period: £215,432,322 (benefit) - £5,483,601 (cost) = £209,948,720 (net present value)

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<sup>31</sup> Personal Social Services Research Unit, *Unit Costs of Health and Social Care 2010*, II Community-based staff, 10. Nurses and doctors, <http://www.pssru.ac.uk/uc/uc2010contents.htm>

## **Wider impacts**

Training: The financial implications of introducing independent prescribing by physiotherapists are listed below. They are based on the assumption that Option 1 is chosen and are the costs that would be realised compared to Option 5 (do nothing). If Options 2-4 were chosen then the implications are likely to be the same as Option 1.

Option 1 will not create any obligatory compliance costs. If healthcare sector organisations decide they wish to take the opportunity to introduce independent prescribing for physiotherapists, the primary costs are for the training course and the supervision by a DMP as part of this. They will be required to pay to train individuals and ensure that individuals maintain accreditation with the relevant professional body.

Training programmes are commissioned locally and existing programmes are multidisciplinary<sup>32</sup> and enable practitioners to access a programme leading to accreditation as independent prescribers – although currently physiotherapists are only assessed as supplementary prescribers. This cost is already identified and is currently funded by the Strategic Health Authorities (SHAs). The cost per head of a non-medical educational programme is £730 in the NHS and £1500 for independent clinicians in the North West. There are also indirect costs associated with the time needed to attend prescribing training courses, which are met locally, as well as the supervising medical practitioner's time.

Physiotherapists who have already successfully completed a supplementary prescribing programme and are annotated as a supplementary prescriber on the physiotherapy HPC register will be able to undertake a conversion programme to become an independent prescriber. The cost of a conversion programme is between £350 and £850. This is an identified 'new' cost but is likely to be time limited and only relevant to existing supplementary prescribers undertaking the conversion programme (a poll indicated that 95% of existing supplementary prescribers would convert to independent prescribers). 'New entrants' into the educational programme would undertake the existing educational programme where the costs are already met by local education commissioners.

Where healthcare sector organisations decide to embark on training physiotherapists to become independent prescribers, it is anticipated that the long-term benefits to patients, services and organisations will outweigh the financial costs. The rationale for this is underpinned by:

- A general acceptance that nurse independent prescribing has shifted some prescribing practice from doctors to nurses with no overall change in prescribing costs.
- Indications that further extending independent prescribing to physiotherapists may reduce the overall number of prescriptions written. For example, a prescribing physiotherapist treating a patient with back pain or shoulder pain will have many different physical treatments they can use, which can mean they need to use pharmaceutical treatment with less frequency. Audit data for 405 patients at Bolton Musculoskeletal Service indicates that only 3% of patients needed new prescriptions, 11% required modification of their medicines to improve therapeutic effect, 39% needed modification or removal to stop medicines misuse (including 2% to stop dangerous misuse) and 1% who needed the removal of medicines to improve care.

Impact on small business: Implementation is voluntary; healthcare organisations would identify the requirements and budget for an independent prescribing role before deciding to embark on the training of physiotherapists to become independent prescribers. A differential is found in the

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<sup>32</sup> Existing multi disciplinary programmes for AHPs, nurses and pharmacists

North West where supplementary prescribing courses cost a clinician from a NHS setting £730 as compared to £1500 for a private independent clinician (these prices are based on bulk buying courses from HEIs).

Physiotherapists in high-street private practice are not required to register with the Care Quality Commission (CQC) for the purposes of independent prescribing.

Equality and fairness: The government wants to facilitate continuing professional development of allied health professionals and enable them to use their skills fully. At present physiotherapists are able to train to become supplementary prescribers. All other allied health professionals, with the exception of the arts therapists, are able to use Patient Group Directions to supply and/or administer medicines.

The government wants to ensure that patients, both in the NHS and independent healthcare sector are treated equitably with better access to medicines, professional skills, efficient and effective services and timely treatment. Reference is made to the equality impact assessment (EIA), which sits alongside this document. The EIA considers and provides broader analysis as to the impact on equality and fairness from a patient/public perspective.

Patients: Physiotherapists as allied health professionals take a patient-centred approach to delivering care. They already work in partnership with patients and the public: many allied health professionals could not do their jobs without a shared decision-making approach. Providing choice that is more informed for patients in accessing the medication they need is an opportunity to affect the quality and safety of direct patient care:

- Medicines legislation underpins the safe and effective use of medicines. In some clinical pathways, the scope of the existing legislation fits well with the needs of patients and enables optimal care. In other pathways, the existing legislation limits the delivery of optimal care, which in turn has the potential to impact upon patient safety
- Physiotherapists are involved in medicines safety committees and non-medical prescribing clinical support networks. There have been no serious incidents or case law relating to AHP medicines use reported to date. For example, NHS North West has a well-established network for promoting the safe and effective use of non-medical prescribing, including a designated AHP lead
- Delayed care can impact negatively upon a patient's experience, reduce treatment effectiveness and potentially place patients at risk. If physiotherapists could independently prescribe, delays in patient care could be avoided and additional GP/medical appointments reduced, impacting positively on the efficacy of care
- The introduction of independent prescribing by physiotherapists facilitates improved access to prescribing and medicines supply mechanisms that could enable some suitably trained and accredited allied health professionals to deliver the prompt care that is needed, thereby avoiding safety risks and the costs of delaying care

This is a crucial opportunity with regard to what physiotherapists could deliver as independent prescribers. The white paper emphasised that it is the outcome for the patient that is important. For example, it will no longer just be about whether medication is accessible as it is also about choice of treatment intervention. Patients want to avoid the inconvenience of multiple appointments with duplication of travel, hospital parking and time off work. Physiotherapy services could improve convenience for patients through extending access to medicines. Patients would need to make fewer additional trips to the doctor in order to manage their medicines.

Patients attending hospital outpatient services in which part or most of their care is allied health professional-led, would need to see fewer individual professionals per visit. Extending access to medicines to traditionally hard-to-reach populations through enhanced physiotherapy services

has potential to reduce health inequalities. For example older people, disabled, traveller and ethnic minority groups are likely to benefit from enhanced, more accessible and responsive services being offered closer to home. Introducing independent prescribing by physiotherapists has the potential to improve access to medicines for patients in rural areas.

There is some evidence<sup>33</sup> that physiotherapists treating certain categories of patients rather than GP centred care will reduce the number of prescriptions required as physiotherapists are often able to explore a wider variety of treatment options than a GP. With independent prescribing status, the physiotherapist can review the patient's existing medication and where physical treatment is appropriate for alleviating conditions, may discuss with the GP the option for reducing the need for some medication<sup>34</sup>.

Although independent prescribing for physiotherapists is predicted to result in savings of GPs' time, the impact on the GP-patient relationship is likely to be minimal. The typical care pathway outlined in benefits section b) includes an initial GP appointment. Therefore the contact between GP and patient is maintained, and this initial appointment still provides an opportunity for the GP to offer other services that may be appropriate for that patient.

Autonomy, accountability and democratic legitimacy: The *'Liberating the NHS'* white paper is about empowering clinicians to serve their local population and one of the most significant of the proposed changes is the devolving of power and responsibility for commissioning. It is crucial that GPs make commissioning decisions that are fully informed by a wide range of clinicians working across all sectors including NHS, local authority, voluntary and private sectors. Dame Carol Black stated in her review that: "*GPs often feel ill-equipped to offer advice to patients on remaining in or returning to work*" (key challenge 5)<sup>35</sup> In contrast, physiotherapists play key roles within innovative rehabilitation schemes and apply a bio-psychosocial and self-directed approach to work injury rehabilitation. Increasing the flexibility with which physiotherapists prescribe and supply medicines as part of this has the potential to improve treatment effectiveness and thereby improve the health of the workforce.

Many groups of patients have regular contact with physiotherapists but rarely see their GP, such as patients with long-term conditions. It is also critical that GPs are informed and aware of alternative models of service delivery such as using tools such as self-referral, triage and non-medical prescribing rights. Extending independent prescribing to physiotherapists can inform GP commissioning consortia of the opportunities and advantages for patients, service delivery and budgets at a local level. Changes to the legislation would enable local commissioners and providers to develop the physiotherapy workforce and local services to meet the needs of patients in the most cost-effective way.

Bureaucracy and efficiency: There is potential for physiotherapists to do more to improve services for patients and to take advantage of the specialist training available to extend the range of prescribing and supply mechanisms than existing arrangements permit.

Existing processes may limit some physiotherapy services from offering a range of prescribing or medicines supply and administration to best meet patient's needs. Problems reported by physiotherapists highlight issues such as requiring numerous PGDs to manage a patient's condition or the availability of a medical practitioner to agree a clinical management plan. Doctor availability provides one of the greatest challenges to successful implementation of supplementary prescribing as many patients do not regularly access GP services and many

<sup>33</sup> Department of Health (2008), *Self-referral pilots to musculoskeletal physiotherapy and the implication for improving access to other AHP services*, London [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_089516](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089516)

<sup>34</sup> Greenhalgh S. (2008), Bolton NHS Musculoskeletal Service. Unpublished audit data.

<sup>35</sup> Black, C. (2008) *Dame Carol Black's review of the health of Britain's working age population: Working for a healthier tomorrow*, London [www.workingforhealth.gov.uk/Carol-Blacks-Review/](http://www.workingforhealth.gov.uk/Carol-Blacks-Review/)

physiotherapists provide services in settings in which a doctor is not present. Similar difficulties are cited in the nursing literature<sup>36</sup>. Other problems reported by physiotherapists and reflected in the literature include uncertainty regarding who the independent medical prescriber should be when patients have complex issues and are under the care of more than one doctor<sup>37</sup> and difficulties when timeframes of care are short, such as short stays in hospital or one-off outpatient appointments<sup>38</sup>.

Value for Money: In the 2009 *Allied health professions prescribing and medicines supply mechanisms scoping project report*<sup>39</sup> several value for money benefits are identified, in addition to patient and clinical benefits, which contributes robust evidence that the long term benefits of introducing independent prescribing by physiotherapists will significantly outweigh initial start up and maintenance costs (primarily training costs).

The benefit is greatest when the prescribing or supply mechanism allows access to medicines in a manner well suited to the needs of patients in an existing service. In such cases, there are several cost-efficiency savings options:

- Either physiotherapists can offer enhanced comprehensive care by prescribing<sup>40</sup>
- Or supply and administering of medicines via mechanisms such as patient group directions (PGDs)
- by offering this more comprehensive service, they make greater choice available to patients and commissioners of services, contributing to the creation of flexible system-wide values
- there is reduced duplication of care, as a patient does not have to see another professional, or another service, in order to receive the required prescription(s) for medicines
- the physiotherapy service often has a lower or competitive unit cost than an alternative provider as they are able to work in a flexible range of settings including the patient's home, as compared to secondary care
- the cost to the patient in both time and monetary cost is reduced, for example because they could take less time off work, reduced number of appointments and reduced travel time and cost

In some cases, the cost saving per case may be substantial. In other cases, the payment-by-results unit cost may be unchanged but improved service efficiency adds to overall value for money. Currently, physiotherapists are only able to add a proportion of the increased value of which they are capable. Further productivity savings could be made if physiotherapists were able to prescribe medicines with greater flexibility. Independent prescribing could enable greater improvements in productivity than can be achieved through supplementary prescribing as illustrated in the following instances:

- clinician time spent organising the clinical management plan (CMP)
- additional follow-up appointments. Outpatient settings such as physiotherapy-led musculoskeletal services run on clinic appointments of about 20–40 minutes. When CMP agreement is not immediate, an additional follow-up appointment is required. This additional and often otherwise unnecessary appointment reduces the productivity of the service

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<sup>36</sup> Courtenay M. and Carey N. (2008) Nurse independent prescribing and nurse supplementary prescribing practice: national survey, *Journal of Advanced Nursing*, 61(3), 291-9

<sup>37</sup> Courtenay M., Carey N. and Burke J. (2007), Independent extended and supplementary prescribing practice: a national questionnaire survey, *International Journal of Nursing Studies*, 44(7), 1093-101

<sup>38</sup> Stenner K. and Courtenay M. (2008), The role of inter-professional relationships and support for nurse prescribing in acute and chronic pain, *Journal of Advanced Nursing*, 63(3), 276-83

<sup>39</sup> Department of Health (2009), *Allied health professions prescribing and medicines supply mechanisms scoping project report*, London [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_103948](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103948)

<sup>40</sup> Prescribed medicines cannot be supplied by the prescriber, they must be supplied by a separate dispenser

Independent prescribing by physiotherapists could result in the need for fewer appointments with other professionals.

Some patients' medication needs could be met by the physiotherapist who is treating their condition in the community, without the need for additional GP or secondary care appointments. This would apply to community physiotherapy services and specialist physiotherapy-led musculoskeletal services. The physiotherapy self-referral pilots indicate that 33% of patients required a prescription for their condition, which suggests that there is potential for large reductions in GP time and appointments in this population. While patients would still have the option of visiting their GP, many would not need to if their physiotherapist could prescribe independently.

Secondary care departments and wards could become more efficient. Physiotherapists who already independently lead units or outpatient clinics would also have the option of independently managing patients' medications in orthopaedic, pain, rheumatology, women's health, neurology and care of older people settings.

It is generally accepted that nurse prescribing has shifted some prescribing practice from doctors to nurses, with no overall change in prescribing costs. There are some early indications that further extending prescribing to physiotherapists may reduce the overall number of prescriptions written. For example, a prescribing physiotherapist treating a patient with back pain or shoulder pain will have many different treatment modalities at their disposal: postural re-education, stretching or strengthening exercise, manual therapy or manipulation, hydrotherapy, cardiovascular fitness programmes and/or medication. It follows that they may need to institute pharmaceutical treatment with less frequency than other professionals who may not have the other modalities at their disposal.

The physiotherapy self-referral pilots included 2,835 patients. Of these, 33% of patients attending physiotherapy on the advice of their GP received a prescription for their condition. Significantly, fewer self-referred patients (24%) required a prescription for their condition<sup>41</sup>.

Information from physiotherapist-led specialist services suggests that prescribing physiotherapists often use supplementary prescribing to assess existing medications and consult with the GP to reduce or stop medications where physical treatment and other mechanisms are effective, although they less frequently prescribed new preparations. Bolton Primary Care Trust's successful consultant physiotherapist-led musculoskeletal service (winner of the *Health Service Journal* award for improving access in 2007) illustrates this. Audit data for 405 patients indicates that while only 3% of patients needed new prescriptions, 49% required modification of their existing medicines regime. This comprised 11% who required modification of their existing dose or preparation to improve therapeutic effect, 37% who needed modification or removal to stop medicines misuse (including 2% to stop dangerous misuse) and 1% who needed the removal of medicines to improve care<sup>42</sup>.

Enforcement and sanctions: The proposals will be implemented through amendments to the Prescriptions Only Medicines (Human Use) Order 1997 and the Medicines (Sale or Supply) (Miscellaneous Provisions) Regulations 1980 which provides exemptions from the Medicines Act restrictions on sale and supply of medicines. There will also be consequential amendments to the Medicines for Human use (Marketing Authorisations etc) Regulations 1994, the Medicines (Child Safety) Regulations 2003 and the Medicines (traditional Herbal Medicines Products for Human Use) regulations 2005. The Medicines and Healthcare products Regulatory Agency

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<sup>41</sup> Department of Health (2008), *Self-referral pilots to musculoskeletal physiotherapy and the implication for improving access to other AHP services*, London [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_089516](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089516)

<sup>42</sup> Greenhalgh S (2008) Bolton NHS Musculoskeletal Service. Unpublished audit data.

(MHRA) is responsible for enforcing medicines legislation on behalf of the Secretary of State. The Health Professions Council is responsible for matters of professional regulation for physiotherapists.

Competition Assessment: Implementation of independent prescribing by physiotherapists is voluntary and would be an option for all providers of healthcare sector organisations. Only those matching the educational programme entry criteria will be able to train and it is not expected that all qualified, eligible physiotherapists will become independent prescribers. It is therefore reasonable to conclude that the proposal will have no adverse effects on competition within the healthcare market. The proposal introduces potential benefits to small private sector business as it opens up options for prescribing that are not viable for most practices currently.

### **Summary and preferred option with description of implementation plan**

While the existing non-medical prescribing arrangements have helped to improve the effectiveness of care for some patients, there is potential for physiotherapists to contribute much more. Service efficiency and innovation are currently hampered by incongruence between the existing mechanisms and patient need.

Option 3 and Option 4 offer independent prescribing with limited conditions and limited formulary respectively and Option 2 offers independent prescribing for both limited formulary and conditions. These options all pose difficulties in terms of the definition of which conditions and which formulary to allow independent prescribing for. When independent prescribing for nurses was implemented it was done so through limited formulary. This proved so complicated in implementation that within one year it was decided that they progress to independent prescribing for any condition from a full formulary.

The introduction of independent prescribing by physiotherapists would quickly allow existing care pathways and more effective, efficient and safe patient care. It would also future-proof healthcare organisations and businesses with a flexible frontline workforce that are capable of leading the development of innovative new care pathways for the benefit of patients. Option 1, independent prescribing by physiotherapists from the full formulary for any condition, was the preferred option by respondents to the public consultation (64%).

## Annexes

Annex 1 should be used to set out the Post Implementation Review Plan as detailed below. Further annexes may be added where the Specific Impact Tests yield information relevant to an overall understanding of policy options.

### Annex 1: Post Implementation Review (PIR) Plan

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. If the policy is subject to a sunset clause, the review should be carried out sufficiently early that any renewal or amendment to legislation can be enacted before the expiry date. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

<p><b>Basis of the review:</b> [The basis of the review could be statutory (forming part of the legislation), i.e. a sunset clause or a duty to review, or there could be a political commitment to review (PIR)];</p> <p>Current data collection mechanisms such as quarterly reports on prescribing volumes in primary care provided by the NHS Information Centre to DH will be reviewed by the Project Board. The Project Board includes representation from the professional body which has indicated that it will be exploring the potential for sub-national and local evaluations of prescribing activity by their members. Non-medical prescribing leads are also represented on the project board and will be able to provide information from sub-national and local reviews.</p> <p>The potential for a research project will be explored by the project board over the next six months including resources required.</p>
<p><b>Review objective:</b> [Is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?]</p> <p>The national, sub-national and local data collection and analysis will provide an ongoing picture of the effectiveness of independent prescribing by physiotherapists, whilst a three year review will provide an analysis of overall progress as compared to the projected costs and benefits.</p>
<p><b>Review approach and rationale:</b> [e.g. describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) and the rationale that made choosing such an approach]</p> <p>The review will make use of mechanisms already in place for other prescribers at national, sub-national and local levels.</p>
<p><b>Baseline:</b> [The current (baseline) position against which the change introduced by the legislation can be measured]</p> <p>The baseline for all future data comparisons will be the data outlined throughout this impact assessment.</p>
<p><b>Success criteria:</b> [Criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives]</p> <p>The success criteria are the improvements of patient experience, patient safety and the provision of flexible services. The costs and benefits data outlined in this document provided a basis upon which to compare. Any modification to the policy will be reviewed once it is assessed whether the policy has met the policy objectives.</p>
<p><b>Monitoring information arrangements:</b> [Provide further details of the planned/existing arrangements in place that will allow a systematic collection of monitoring information for future policy review]</p> <p>The NHS Information Centre quarterly reports are based on data from ePACT for all prescribed products in England and dispensed in the community. The Information Centre produces more detailed reports down to prescriber at SHA level for example.</p> <p>Use will also be made of regional and local audits. Evaluations by the professional body will include private practitioners.</p>



**Reasons for not planning a review:** [If there is no plan to do a PIR please provide reasons here]

N/A

## Annex 2: Projection of costs and benefits of introducing independent prescribing

### Detailed costs and benefits of Option 1: Independent prescribing for physiotherapists for all conditions from a full formulary

Total costs and benefits are those accrued as a result of (1) those converting from supplementary prescribers to independent prescribers via conversion independent prescribing educational programmes and (2) those with no previous prescribing qualifications becoming independent prescribers via a full independent prescribing educational programme.

#### 1 Conversion educational programmes undertaken to convert from supplementary prescribing to independent prescribing

There were 204 supplementary prescribing physiotherapists in the UK in September 2011. As a result of a sample survey of physiotherapist supplementary prescribers it is estimated that 96% (196) will convert to independent prescribing in the UK. It is assumed they will convert over the first 2 years and then conversion programmes for physiotherapists will no longer be available. It is assumed that sufficient places will be available on conversion courses to meet demand (with 60% converting in year 1 and 40% in year 2).

Number of supplementary prescribers in the UK as of 31st Aug 2011: <http://www.hpc-uk.org/publications/foi/index.asp?id=500>  
Sample survey: via correspondence

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
<b>Projected demand for conversion independent prescribing educational programmes</b>												
Number of supplementary prescribing physiotherapists converting to independent prescribing	0	118	78									

#### Projected resulting number of first appointments available with an independently prescribing physiotherapist in the UK (one appointment = one new patient) as a result of conversion from supplementary prescribing (SP)

It is estimated that there are, on average, 31 first appointments per year per physiotherapist in the UK. This is based on there being 680,645 first appointments with NHS physiotherapists in England in 2010-11 and 22,029 physiotherapists working in NHS England in 2010. This gives an average 31 first appointments with physiotherapists in the NHS per year, which is assumed here to be true also in the private sector and in the other countries of the UK.

NHS Information Centre Hospital Episode Statistics  
(<http://www.hesonline.nhs.uk/Ease/servelet/ContentServer?siteID=1937&categoryID=895>) and NHS Staff 2000-2010: Non-medical staff 2010 (<http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-2000-2010-non-medical>)

Additional first appointments available with an independently prescribing physiotherapist = (number of supplementary prescribers converting to independent prescribing) x (average number of first appointments per physiotherapist)	0	3,658	2,418	0	0	0	0	0	0	0	0	0
Projected number of appointments available with an independently prescribing physiotherapist per year (as a result of conversion from SP)	0	3,658	6,076	6076	6076	6076	6076	6076	6076	6076	6076	6076

#### 2 Full independent prescribing educational programmes, for those with no previous prescribing qualifications

The duration of the full independent prescribing course is 6 months, and the first courses are likely to be available to physiotherapists from September 2013. The benefits will therefore not be realised until year 2, and so a value of zero has been used for the resulting number of appointments in year 1 (as a result of the full training). Available places are projected based on 8% of places being taken by physiotherapists. In reality, this will be flexible as the courses are multidisciplinary and able to accommodate more physiotherapists if demand is high.

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
<b>Supply of independent prescribing educational programmes</b>												
Estimated increase in provision of independent prescribing educational programmes	0%	0%	10%	10%	10%	0%	0%	0%	0%	0%	0%	
Projected availability of places on independent prescribing education programmes per year	2,750	2,750	3,025	3,328	3,660	3,660	3,660	3,660	3,660	3,660	3,660	
Projected number of places available to physiotherapists on independent prescribing programmes per year (based on 8% uptake)	0	220	242	266	293	293	293	293	293	293	293	

Assumption: supply of training places will expand by 10% in years 2, 3 and 4, via current training providers offering additional cohorts.

In the UK there are currently 55 training providers accredited with the HPC: <http://www.hpc-uk.org/education/programmes/register>. Assumption of 50 places per year for each, based on: 100 places at Bolton University, 50 at Leeds Metropolitan and 40-60 at City University.

Courses are attended by several professions, including nursing. Given that nursing is 10 times the size of physiotherapy, the assumed availability of places for physiotherapists is 8%.

**Demand for independent prescribing educational programmes**

It is assumed that 5% of physiotherapists will take up independent prescribing (IP). Between 2 and 3% of nurses have undertaken IP, and for physiotherapists this is likely to be higher due to the nature of their practice. There are currently 37,015 fully practising members of the Chartered Society of Physiotherapy in the UK who are not already supplementary prescribers. It is assumed that 5% of these will want to train as independent prescribers over the first 5 years. In addition, it is assumed that 5% of all newly-eligible physiotherapists will train each year (168 per year). The figure of 5% is supported by a sample survey of podiatrists; there are comparable categories of physiotherapists with equal benefit and interest to support this figure. The high demand for places in years 1 to 5 would require education providers to take on a higher proportion of physiotherapists (around 20% of places) in these multiprofessional courses or by running extra cohorts. Rather than assuming such a high uptake, we have assumed that 8% of places will be filled by physiotherapists in years 1 to 5, and 168 places per year in years 6 to 10 ('supply' of places used in years 1 to 5 as demand exceeds supply, 'demand' for places used in years 6 to 10).

Projected demand of independent prescribing educational programmes by physiotherapists per year	0	539	538	538	538	538	168	168	168	168	168
Cumulative number of physiotherapists completing the full independent prescribing training programme ('supply' in years 1 to 5 and 'demand' in years 6 to 10)	0	220	462	728	1,021	1,314	1,482	1,650	1,818	1,986	2,154

Sample survey: figure of 5% based on responses from approximately 400 podiatrists who are currently eligible to take up IP. It is estimated that approx 8% of those currently eligible will take up IP over the first 3-5 years. This equates to between 5% and 6% of the total number of practising podiatrists. Physiotherapy is comparable to podiatry in terms of the potential interest and benefit amongst eligible practitioners.

Number of newly-qualified physiotherapists each year registering with the HPC: <http://www.hpc-uk.org/assets/documents/10003A2CFR01584Physiotherapists-numbersofregistrations2003-2012.pdf>  
An average for the last 5 years is taken (4,197). 80% of all physios registered with the HPC are full-practising members (37,219 of 46,689). Therefore 80% of yearly registrations used as a proxy for the number of physiotherapists who are newly eligible for IP training each year (3,358).

**Resulting number of first appointments available with an independently prescribing physiotherapist in the UK (one appointment = one new patient) as a result of full independent prescribing educational programmes**

Projected number of first appointments available with an independently prescribing physiotherapist per year (full training programme)	0	0	6,820	14,322	22,574	31,652	40,729	45,937	51,145	56,353	61,561
Total projected first appointments available with an independently prescribing physiotherapist (sum for both types of training programme)	0	3,658	12,896	20,398	28,650	37,728	46,805	52,013	57,221	62,429	67,637

This is zero in year 1 as the full independent prescribing course is of duration 6 months, with the first courses available for physiotherapists projected to be during year 1. The benefits will therefore not be realised until year 2.

**Costs of Option 1: Independent prescribing for all conditions from a full formulary for physiotherapists**

**a) Educational programme costs for supplementary prescribers converting to independent prescribers**

Based on the estimated cost of £600 per conversion educational programme, sourced through correspondence with Professional Leadership Officer at the Department of Health..

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Cost of conversion programmes = (cost of one conversion programme)x(number of conversion programmes undertaken each year)	£0	£70,800	£46,800									
Discount at 3.5%	£0	£70,800	£45,217									£116,017

**b) Educational programme costs for those with no prescribing background, training as independent prescribers**

Based on the estimated cost of £1,250 per full independent prescribing educational programme, sourced through correspondence with Professional Leadership Officer at the Department of Health..

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Estimated cost of full independent prescribing courses undertaken	£0	£275,000	£302,500	£332,750	£366,025	£366,025	£210,000	£210,000	£210,000	£210,000	£210,000	
Discounted at 3.5%	£0	£275,000	£292,271	£310,626	£330,134	£318,970	£176,814	£170,835	£165,058	£159,476	£154,084	£2,353,267

**c) Cost of supervision by a designated medical practitioner (DMP)**

Training requires 12 days (78 hours) of learning in practice, with a DMP as a mentor. The time commitment will vary according to local practice and individual need. The majority of time will be spent in a clinical setting, while the DMP is undertaking their normal duties, so there is no time 'cost'. Some time will be dedicated solely to acting as DMP (e.g. reviewing competencies and log book); we have estimated one hour of a GP's time per day. The cost per hour of GMS activity is £121, resulting in a cost per physiotherapist of 12 x £121=£1,452.

Cost per hour of GMS activity:  
http://www.pssru.ac.uk/uc/uc2010contents.htm

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Number of independent prescribing educational programmes undertaken each year (for years 1 and 2 this is the sum of both types of training programme)	0	338	320	266	293	293	168	168	168	168	168	168
Total cost of DMP supervision for all physiotherapists training as independent prescribers	£0	£490,776	£464,640	£386,522	£425,175	£425,175	£243,936	£243,936	£243,936	£243,936	£243,936	£243,936
<b>Discounted at 3.5%</b>	<b>£0</b>	<b>£490,776</b>	<b>£448,928</b>	<b>£360,823</b>	<b>£383,483</b>	<b>£370,515</b>	<b>£205,388</b>	<b>£198,442</b>	<b>£191,731</b>	<b>£185,248</b>	<b>£178,983</b>	<b>£3,014,317</b>
<b>Total projected financial cost</b>	<b>£0</b>	<b>£836,576</b>	<b>£786,415</b>	<b>£671,448</b>	<b>£713,617</b>	<b>£689,485</b>	<b>£382,202</b>	<b>£369,277</b>	<b>£356,790</b>	<b>£344,724</b>	<b>£333,067</b>	<b>£5,483,601</b>

**Benefits of Option 1: Independent prescribing for all conditions from a full formulary for physiotherapists**

**a) Health benefit to patients from timely treatment, thereby reducing risk of acute condition becoming a long term condition (LTC) (or of an exacerbation of an existing LTC)**

Currently, if a physiotherapist suggests a prescription, the patient must access it via their GP. The patient pathway is physiotherapist --> GP, which can take between 24 hours and 2 weeks. This time delay in accessing the prescription creates a window for the patient's condition to deteriorate, and at worst can develop into a LTC (or an exacerbation of an existing LTC). Quality Adjusted Life Years (QALYs) take into account the impact of a health intervention on an individual, allowing for the quality and quantity of life change as a result. A moderate estimate of 3% is used for the risk of an acute condition becoming a LTC (or an exacerbation of an existing LTC). There is a lack of definitive evidence for this figure, so a range from 1% to 5% is used in this impact assessment.

Quality of life deterioration as a result of the acute condition becoming a LTC = 0.2,  
Benefit calculation restricted to 1 year as a conservative estimate.  
Resulting number of Quality Adjusted Life Years (QALYs) = (quality of life deterioration)x(number of years of deteriorated state of health) = 0.2 x 1 = 0.2  
Resulting financial benefit per patient = (number of QALYs)x(value of 1 QALY) = 0.2 x £60,000 = £12,000

Reference: Kind P., Hardman G. and Macran S. (1999), UK Population Norms from EQ-5D. University of York Discussion Paper 172. Page 3, table 3 refers to the coefficients for average (2) and poor (2) state of pain/discomfort in health as 0.123 and 0.286. 0.2 used as a moderate estimate.

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Estimated number of patients that would receive this health benefit as a result of IP for physiotherapists (3% of total first appointments with an IP physiotherapist)	0	110	387	612	860	1,132	1,404	1,560	1,717	1,873	2,029	
Resulting estimated financial health benefit = (financial benefit per patient)x(number of patients that independent prescribing reduces risk for)	£0	£1,316,880	£4,642,560	£7,343,280	£10,314,072	£13,581,943	£16,849,814	£18,724,694	£20,599,574	£22,474,454	£24,349,334	
<b>Discounted at 1.5% per year</b>	<b>£0</b>	<b>£1,316,880</b>	<b>£4,573,951</b>	<b>£7,127,841</b>	<b>£9,863,522</b>	<b>£12,796,693</b>	<b>£15,641,014</b>	<b>£17,124,523</b>	<b>£18,560,768</b>	<b>£19,950,823</b>	<b>£21,295,739</b>	<b>£128,251,755</b>

**b) Reductions in GP requirements**

Independent prescribing would save a visit to the GP for those requiring a prescription. Some patients would require a GP appointment but this would not be the case for all. As a conservative estimate, we have assumed that the GP would save 5 minutes of time per patient to assess the patient notes and issue the prescription.  
 Number of first appointments with a physiotherapist in the UK in a year = 816,571  
 Calculated as number of first appointments with an NHS physiotherapist in England in 2010-11, multiplied (using GP registered population data) to obtain a figure for the UK (and assumed to be the same each year thereafter)  
 Number of physiotherapy appointments estimated to require a prescription = (number of first appointments with a physiotherapist)x(proportion of appointments requiring a prescription) = 816,571 x 33% = 269,468  
 5 minutes of GMS activity = £10.08

England figure obtained from: <http://www.hesonline.nhs.uk/Ease/serve/ContentServer?siteID=1937&categoryID=895>  
 33% from: P.16 DH (2008), 'Self-referral pilots to musculoskeletal physiotherapy and the implications for improving access to other AHP services'  
 GMS activity cost: <http://www.pssru.ac.uk/uc/uc2010contents.htm>

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Number of appointments that require a prescription and are covered by independent prescribing physiotherapists	0	1,207	4,256	6,731	9,455	12,450	15,446	17,164	18,883	20,602	22,320	
Projected financial savings to GP practices in the UK = (number of appointments requiring prescription and covered by independent prescribers)x(cost of GP time to issue prescription)	£0	£12,168	£42,897	£67,852	£95,302	£125,497	£155,692	£173,016	£190,340	£207,664	£224,988	
<b>Discounted at 3.5% per year</b>	<b>£0</b>	<b>£12,168</b>	<b>£41,447</b>	<b>£63,340</b>	<b>£85,957</b>	<b>£109,364</b>	<b>£131,089</b>	<b>£140,749</b>	<b>£149,606</b>	<b>£157,702</b>	<b>£165,081</b>	<b>£1,056,502</b>

**c) Reduction in patient's time away from work to access a prescription**

For those patients who work, there will be a saving for not having to attend the GP practice to access a prescription. A moderate assumption is that a typical visit to the GP to access a prescription takes 45 minutes. This results in loss of earnings of £8.40 per patient, given the average hourly wage in the UK of £11.20.  
 This saving is applied here to the proportion of resident UK population who are in employment: 29,129,000/50,339,000=0.58  
 There will be additional savings (not included in calculations) from reduced travel costs for these patients.

Average earnings: Table 1.5a, median hourly rate for all employees in the UK (provisional 2011 data): <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-235202>  
 Proportion in employment: Labour Market Statistics, Feb 2012: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-222474>

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Number of appointments (that require a prescription and are covered by an independently prescribing physiotherapist) that are taken by patients who are employed	0	700	2,468	3,904	5,484	7,221	8,958	9,955	10,952	11,949	12,946	
Projected saving to patients for not having to attend GP practice to access their prescription per year = (average earnings lost from attending GP practice)x(number of appointments taken by patients who are employed)	£0	£5,881	£20,734	£32,795	£46,063	£60,657	£75,251	£83,624	£91,998	£100,371	£108,744	
<b>Discounted at 3.5% per year</b>	<b>£0</b>	<b>£5,881</b>	<b>£20,033</b>	<b>£30,615</b>	<b>£41,546</b>	<b>£52,859</b>	<b>£63,360</b>	<b>£68,029</b>	<b>£72,309</b>	<b>£76,223</b>	<b>£79,789</b>	<b>£510,642</b>

**d) Reduced prescriptions required due to more specialist treatment from physiotherapist**

Independent prescribing will give physiotherapists a greater ability to treat their patients; physiotherapy patients will increasingly receive specialist treatment. There is evidence that this more specialist treatment, and the longer consultation time (30 minutes for physiotherapists on average compared with 11 minutes for a GP) will result in a 14% reduction in prescriptions required  
 This saving is calculated based on the prescription charge of £7.65 in England. There is no prescription charge for patients in the other countries of the UK but the cost of the prescription must still be met by the Government. The cost per prescription for Scotland, Wales and Northern Ireland is greater than the standard prescription charge in England, so this is used as a conservative estimate for the whole of the UK.

14% from: Page 17, DH (2008), 'Self-referral pilots to musculoskeletal physiotherapy and the implications for improving access to other AHP services'  
 Assumption: there is one prescription per appointment.

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Estimated number of first appointments with a physiotherapist each year that require a prescription	0	1,207	4,256	6,731	9,455	12,450	15,446	17,164	18,883	20,602	22,320	
Projected reduction in number of prescriptions required	0	169	596	942	1,324	1,743	2,162	2,403	2,644	2,884	3,125	
Projected financial saving = (cost of a prescription)x(projected reduction in prescriptions required)	£0	£1,293	£4,558	£7,209	£10,126	£13,334	£16,542	£18,383	£20,224	£22,064	£23,905	
<b>Discounted at 3.5% per year</b>	<b>£0</b>	<b>£1,293</b>	<b>£4,404</b>	<b>£6,730</b>	<b>£9,133</b>	<b>£11,620</b>	<b>£13,928</b>	<b>£14,955</b>	<b>£15,896</b>	<b>£16,756</b>	<b>£17,540</b>	<b>£112,253</b>
<b>Total projected financial saving</b>	<b>£0</b>	<b>£1,336,222</b>	<b>£4,639,834</b>	<b>£7,228,526</b>	<b>£10,000,158</b>	<b>£12,970,535</b>	<b>£15,849,391</b>	<b>£17,348,255</b>	<b>£18,798,579</b>	<b>£20,201,504</b>	<b>£21,558,148</b>	<b>£129,931,152</b>

33% from: Page 16, DH (2008), 'Self-referral pilots to musculoskeletal physiotherapy and the implications for improving access to other AHP services'  
 Assumption: there is one prescription per appointment.

**Total costs and benefits across conversion independent prescribing educational programmes and full independent prescribing educational programmes**

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Annual Cost	£0	£836,576	£786,415	£671,448	£713,617	£689,485	£382,202	£369,277	£356,790	£344,724	£333,067	£5,483,601
Annual Benefit	£0	£1,336,222	£4,639,834	£7,228,526	£10,000,158	£12,970,535	£15,849,391	£17,348,255	£18,798,579	£20,201,504	£21,558,148	£129,931,152
Projected 10 year net benefit:											£124,447,551	

## Annex 3: References

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