### DH INFORMATION READER BOX

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#### Document purpose
For information

#### Gateway reference
12185

#### Title
Allied health professions prescribing and medicines supply mechanisms scoping project report

#### Author
Department of Health

#### Publication date
15 July 2009

#### Target audience
PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, local authority Directors of HR, Directors of Finance, allied health professionals, GPs

#### Circulation list

#### Description
Report of an initial piece of work to determine if there is an evidence base for further work to extend the prescribing and medicines supply mechanisms used by the allied health professions. The report makes recommendations for future phased work.

#### Cross-reference
N/A

#### Superseded documents
N/A

#### Action required
N/A

#### Timing
N/A

#### Contact details
Shelagh Morris  
Room 5E58  
Quarry House  
Quarry Hill  
Leeds  
LS2 7UE  
www.dh.gov.uk/en/Aboutus/Chiefprofessionalofficers/

#### For recipient’s use
Allied health professions prescribing and medicines supply mechanisms scoping project report

July 2009

Prepared by: Darryn Marks, Project Manager
To deliver safe and effective healthcare that also provides a good experience for patients, we need to ensure that we are maximising the full potential of our entire clinical workforce. We need to enable quality improvement, innovation and greater productivity in service delivery.

This report presents the findings of the allied health professions prescribing and medicines supply mechanisms scoping project. The objective of this work was to determine if there is an evidence base for further work to extend the prescribing and medicines supply mechanisms that can be used by allied health professionals to enhance the quality of care that patients, wherever they are treated, receive.

While a full public consultation is required before any changes can be made to the prescribing mechanisms available to allied health professionals, this initial piece of work does demonstrate the limitations of the current situation and how the quality of care received is compromised. This is a particular issue in primary care and community settings and, as we strive to deliver more care closer to home, it is important for the Department of Health to anticipate future need and models of service delivery.

I commend this report to you as an example of work that has been clinically led, with the patient experience central to its development. It has been co-produced by a range of key stakeholders and overseen by a Project Board whose membership has been exemplary in challenging the evidence produced, to be certain that any work to extend prescribing or medicines supply mechanisms for certain allied health professions will improve safety, effectiveness and the patient experience.

Lastly, I would like to acknowledge and thank Darryn Marks, Consultant Physiotherapist and Assistant Director of Therapies at Barnsley Primary Care Trust for his excellent stewardship of this project.

Karen Middleton
Chief Health Professions Officer, England
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Executive summary

Background

This report presents the findings of the allied health professions prescribing and medicines supply mechanisms scoping project. It was prepared for the Chief Health Professions Officer, England and subsequently presented to the Department of Health’s (DH’s) Non-Medical Prescribing Board.

The existing arrangements by which allied health professionals prescribe and supply medicines to their patients are complex. Supplementary Prescribing training is available to experienced and expert physiotherapists, podiatrists and radiographers. Patient Group Directions for supply and administration of medicines are available to all allied health professionals with the exception of art therapists, music therapists and dramatherapists. Exemptions are used by podiatrists and all the professions can supply and administer medicines under Patient Specific Directions.

Clinicians have questioned whether these arrangements best serve the needs of patients, and in the context of current healthcare policy, whether they support the vision for the future of healthcare.

The primary intention of this project was to establish whether there is evidence of service and patient need, to support extending prescribing and medicines supply mechanisms available to the allied health professions (AHPs).

Policy context

*High quality care for all: NHS Next Stage Review final report*¹ creates a vision for the health service in which frontline staff are empowered to lead change that will improve the effectiveness of care and the patient experience. *NHS Next Stage Review: Our vision for primary and community care*² is now being taken forward via the Transforming Community Services (TCS) programme. It promotes collaboration across traditional boundaries to provide more integrated care closer to home and empowers patients to make their own choices about their health and healthcare. *A high quality workforce: NHS Next Stage Review*³ endorses an

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increasingly flexible, responsive and patient-focused workforce. Tomorrow’s clinicians have the opportunity to be a practitioner, partner and leader.

Framing the contribution of allied health professionals: Delivering high-quality healthcare highlights the role of allied health professionals as first-contact practitioners performing assessment, diagnosis, treatment and discharge, from primary prevention through to specialist disease management and rehabilitation. The improved allied health professions service offer announced by the Secretary of State for Health in October 2008 supports allied health professionals to improve access through expansion of self-referral schemes.

Medicines and prescribing legislation underpins the safe and effective use of medicines. It has potential for far-reaching influence upon service transformation and the delivery of policy vision. By adapting to advances in healthcare delivery, the legislation can enable clinicians to improve the patient experience through new roles, new ways of working, extended roles and service redesign – enabling flexible, responsive and proactive services.

Summary of findings

Allied health professionals use the existing mechanisms safely and effectively to improve patient care in clinical pathways where the application of the mechanisms are suited to the needs of patients. However, the needs of patients in many pathways cannot be met by the existing arrangements. Incompatibility between the mechanisms available to allied health professionals and the needs of patients impacts negatively on safety, effectiveness, patient experience and productivity.

Greater flexibility of prescribing and medicines supply by allied health professionals has the potential to reduce treatment delays, improve specificity and responsiveness of prescribing and thereby reduce patients’ exposure to safety risks. Safety considerations relate to training arrangements, communication of prescribing and governance arrangements, none of which are unique to allied health professionals.

Extension of prescribing and medicines supply for certain allied health professions would improve the patient experience, by allowing patients greater access, convenience and choice.

In many clinical pathways the allied health professional is a key or lead clinician, yet they are unable to optimise the effectiveness of patient care because they do not have access to the appropriate prescribing mechanisms. Providing greater prescribing flexibility for specific allied health professions would future-proof the NHS with a flexible frontline workforce, capable of leading the development of innovative new care pathways for the benefit of patients.

A more flexible workforce offers potential to improve value for money. There is a negative cost implication to maintaining the status quo, because service efficiency and innovation are currently hampered by incongruence between the existing mechanisms and patient

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need. It is likely that savings made through fewer appointments and potentially fewer prescriptions will outweigh training costs.

Allied health professionals have different roles and variable experience in the use of medicines. Consequently, the case for change is different for each profession.

**Conclusions**

There is a strong case for progression to Independent Prescribing for physiotherapists and podiatrists. There is some evidence supporting a progression to Independent Prescribing for radiographers but less than exists for physiotherapists and podiatrists.

There is a strong case for progression to Supplementary Prescribing for dietitians. There may also be a case for progression to Supplementary Prescribing for speech and language therapists, orthoptists and occupational therapists.

There is a strong case in support of Exemptions for orthoptists, for a specific list of preparations used in the diagnosis and treatment of disorders of binocular vision. The possibility of a specific list of Exemptions might also be considered alongside Supplementary Prescribing for dietitians.

The prioritisation of recommended work is based on clinical need in the context of NHS reforms.

**Recommendations**

All recommendations have been endorsed by the DH Non-Medical Prescribing Board, which agreed that the work would need to be planned to take account of DH and Medicines and Healthcare products Regulatory Agency resources available.

**Phase 1 – further work should be undertaken to establish:**

> Independent Prescribing by physiotherapists;
> Independent Prescribing by podiatrists;
> Supplementary Prescribing by dietitians, and consideration of a specific list of potential Exemptions for dietitians; and
> a specific list of Exemptions for orthoptists.

**Phase 2 – further work should be undertaken, when appropriate, to consider the need for:**

> Independent Prescribing by radiographers;
> Supplementary Prescribing by speech and language therapists;
> Supplementary Prescribing by orthoptists; and
> Supplementary Prescribing by occupational therapists.

Consideration should also be given to supporting coordinated research into the impact of allied health professionals prescribing on patients, services and prescribing trends. This research should be conducted alongside development of practice and should not delay change.
1. Introduction

1.1 Feedback from many allied health professionals and some other clinicians has suggested that the existing arrangements for prescribing and medicines supply by allied health professionals do not best serve the needs of patients. This feedback highlighted a need to consider whether the quality of patient care could be improved by changes to the medicines legislation.

Terms of reference

1.2 The allied health professions (AHP) prescribing and medicines supply mechanisms scoping project was established in September 2008, in order to:
   > establish whether there is evidence of service and patient need to support extending non-medical prescribing (NMP) and medicines supply mechanisms for AHPs; and
   > report the findings to the Chief Health Professions Officer, making recommendations about further work to be undertaken.

Criteria for considering change

1.3 *High quality care for all: NHS Next Stage Review final report*\(^5\) refers to three key elements of quality within a health service: safety, effectiveness and patient experience. The NHS Operating Framework 2009/10\(^6\) adds value for money to this list. Any judgement about whether to extend AHP prescribing and/or mechanisms of medicines supply would therefore need to consider the following criteria:
   > Does the profession possess sufficient ability and knowledge in the safe and effective management of medicines to support the change?
   > Would it safely enhance the patient experience?
   > Would it safely enhance clinical effectiveness?
   > Would it improve value for money?

Background: current prescribing and supply of medicines by allied health professionals

Legal mechanisms

1.4 The following are the legal mechanisms enabling specified healthcare practitioners to prescribe and supply/administer medicines:
   > Patient Specific Directions;

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Patient Group Directions; Exemptions; Supplementary Prescribing; and Independent Prescribing.

Further detail of these mechanisms is contained in Appendix 5.

**Mechanisms available to each allied health profession**

1.5 Allied health professionals are a diverse group of clinicians and this is reflected in the variation of prescribing and medicines supply and/or administration mechanisms currently available to each profession. In Table 1 the mechanisms available to each profession are indicated by shaded boxes. The year in which a mechanism became available to each profession is also indicated. Patient Specific Directions are available to all professions and carers and does not have a year marked.

**Table 1. Mechanisms available to each allied health profession with dates**

<table>
<thead>
<tr>
<th>Allied health profession</th>
<th>Patient Specific Directions</th>
<th>Patient Group Directions</th>
<th>Exemptions</th>
<th>Supplementary Prescribing</th>
<th>Independent Prescribing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapists</td>
<td></td>
<td>2000</td>
<td>2005</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiographers</td>
<td></td>
<td>2000</td>
<td>2005</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietitians</td>
<td></td>
<td>2003</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech and language therapists</td>
<td></td>
<td>2003</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational therapists</td>
<td></td>
<td>2003</td>
<td></td>
<td></td>
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<tr>
<td>Orthoptists</td>
<td></td>
<td>2003</td>
<td></td>
<td></td>
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<tr>
<td>Prosthetists and orthotists</td>
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<td>2003</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Art therapists</td>
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<td></td>
</tr>
<tr>
<td>Music therapists</td>
<td></td>
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<td>Dramatherapists</td>
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</table>
2. Policy context

2.1 Medicines and prescribing legislation, as summarised in *Medicines Matters*,\(^7\) underpins the safe and effective use of medicines. This legislation, together with recent policy (as detailed below), has potential for far-reaching influence upon service transformation and the delivery of policy vision. By adapting to advances in healthcare delivery, medicines legislation can enable clinicians to improve the patient experience through new roles, new ways of working, extended roles and service redesign, enabling flexible, responsive and proactive services.

2.2 *High quality care for all*\(^8\) sets out the vision for the NHS in the future. Central to the vision is quality, which has three key elements as illustrated below:

**Figure 1. Quality at the heart of the NHS**

- Help to stay healthy
- Empowering patients
- Most effective treatments for all
- Keeping patients as safe as possible

- Raising standards
- Stronger involvement of clinicians in decision making at every level of the NHS
- Fostering a pioneering NHS

- Empowering frontline staff to lead change that improves quality for patients
- Valuing the work of NHS staff

2.3 *NHS Next Stage Review: Our vision for primary and community care*\(^9\) promotes personalised, responsive, high-quality services, which are convenient and accessible. Services will develop in an environment which supports clinical leadership and innovation. Clinicians will work collaboratively across traditional boundaries to provide more integrated care, which empowers patients to make their own choices about their health and healthcare.

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2.4 A high quality workforce\textsuperscript{10} describes a vision that puts quality at the heart of the service and gives staff the freedom to focus on quality. It endorses an increasingly flexible, responsive and patient-focused workforce. Tomorrow’s clinicians have the opportunity to be a practitioner, partner and leader. Practitioners will use professional judgement, creativity and innovation to keep people healthy as well as treating them when they are sick. Partnership will be within and across professions and organisations to integrate care around patients, taking responsibility for stewardship and management of finite healthcare resources. Leadership will be at a variety of levels – clinical team, services, departments, organisations and the wider NHS – changing the system where it would benefit patients.

2.5 The Operating framework for the NHS in England 2009/10\textsuperscript{11} describes the three stages of a journey that commenced with the NHS Plan in 2000. The first stage was to increase capacity and investment, while the second stage introduced levers to enable reform. The third stage, heralded by High quality care for all, focuses on using the additional capacity and the reform levers to transform services to deliver high-quality care. Primary care trusts (PCTs) are expected to support new service models, including self-referral to allied health professionals.

2.6 Framing the contribution of allied health professionals: Delivering high-quality healthcare\textsuperscript{12} highlights the role of allied health professionals as, in the main, first-contact practitioners. Allied health professionals perform functions of assessment, diagnosis, treatment and discharge throughout the care pathway, from primary prevention through to specialist disease management and rehabilitation. The improved AHP service offer announced by the Secretary of State for Health in October 2008 supports allied health professionals to deliver many of the aspirations of High quality care for all. The three key strands of the improved AHP service offer are:

> to mandate the collection of referral to treatment time for AHP services (from April 2010) – within the community services data set – and provide support to implement AHP service transformation;
> to improve access – making use of self-referral\textsuperscript{13} to AHP services where clinically appropriate; and
> to improve quality and empower patients:
  – ensuring that the work to develop an integrated set of quality metrics has a clear focus on metrics related to services provided by clinical teams, including allied health professionals;


– empowering patients to use AHP services through piloting personal budgets;
– encouraging use of information budgets by AHP services; and
– encouraging allied health professionals to engage with the integrated care organisation pilots.

2.7 The three strands of the improved AHP service offer are being taken forward as part of the Transforming Community Services Programme that is being co-produced with clinicians and leaders from across health and social care services. Figure 2 illustrates the aims and delivery streams of the programme.

The programme focuses on six clinical improvement areas:
> promoting health and well-being and reducing inequalities;
> children and families;
> acute services closer to home;
> services for rehabilitation and long-term neurological conditions;
> services for long-term conditions; and
> end-of-life care.

Figure 2. Transforming Community Services Programme


2.8 By October 2009, PCT commissioners will have developed a detailed plan for transforming community services, including how they intend to enhance patient choice. There are a range of options enabling new patterns of provision for community services, including PCT provider services, community foundation trusts and social enterprises. These empower clinicians to shape services and provide opportunities to deliver modern, world-class, innovative community services that have direct benefit to patients.
2.9 Modernising allied health professions (AHP) careers: a competence-based career framework\textsuperscript{14} demonstrates for individuals and commissioners the variety of roles that allied health professionals can perform in order to contribute to service improvement and transformation. The first Modernising AHP Careers (MAHPC) Education Summit, held in December 2008, identified the priorities for MAHPC Phase 2. One of the work streams in Phase 2 is supporting the development of advanced practice. AHP advanced practitioners have potential to make use of prescribing and medicines supply mechanisms to meet the needs of patients.

2.10 Improving health and work: changing lives\textsuperscript{15} is the Government’s response to Dame Carol Black’s review of the health of Britain’s working-age population. It sets out three key areas for delivery of the broader vision:

- creating new perspectives on health and work;
- improving work and workplaces; and
- supporting people to work.

2.11 An example of the initiatives identified is the ‘Fit for Work’ service pilots, which will provide case-managed, multidisciplinary support, with various models being tested and evaluated. Allied health professionals can prevent unnecessary absence from work and promote early return to work, as well as supporting those who are not in work, to seek work. Prescribing and medicines supply mechanisms can enable timely and responsive services to be delivered.


3. Project governance

Project Board

3.1 A Project Board was established to oversee the project (see Appendix 1).

Scope

3.2 The project covered:
   > all non-medical prescribing and medicines supply mechanisms in use in England; and
   > all allied health professions, with the exception of paramedics who are covered by a separate initiative within the urgent and emergency care work programme.

Processes

3.3 A number of individuals, organisations and groups contributed to the project:
   > allied health professional bodies and the Allied Health Professions Federation (AHPF);
   > strategic health authority AHP leads;
   > strategic health authority non-medical prescribing leads;
   > AHP Consultant Group;
   > individuals from medical, nursing and pharmacy professions and regulatory bodies;
   > individual commissioners and NHS managers;
   > individual allied health professionals; and
   > the North-West AHP Non-Medical Prescribing Network.

3.4 The following groups were not approached for contribution at this early stage. Their involvement in any future work is essential and would form part of any formal consultation:
   > patient groups and the general public;
   > higher education institutions; and
   > professional bodies, e.g. medical, nursing and pharmacy.

3.5 Information was received in a variety of formats:
   > published literature;
   > audit data;
   > anecdotes to illustrate what might improve the patient experience;
   > case studies; and
   > views and opinions.
3.6 Two workshops were conducted for leading clinicians involved in the prescribing and supply of medicines from all the allied health professions.

3.7 The devolved administrations were kept informed of the project.

Impact assessments

3.8 A full Impact Assessment is not required for this early stage work. A developmental impact assessment has been initiated to inform any future work.

3.9 A recent, but yet to be published, Equality Impact Assessment covering all professions involved in non-medical prescribing is applicable to this work.
4. Current use of medicines supply and prescribing mechanisms by allied health professionals

4.1 Allied health professionals are a diverse group, often highly specialised within their clinical field (see Appendix 2). The Health Professions Council is the statutory regulator for allied health professionals, wherever they work in the UK (see Appendix 3).

4.2 An expansion in allied health professionals’ roles and responsibilities over recent years has coincided with increased use of medicines. Currently medicines supply and prescribing mechanisms are used to a varying degree by the different professions.

4.3 Physiotherapists have been using medicines for injection therapy since the early 1990s via doctors’ directions and Patient Specific Directions (PSDs). Since 2000, local anaesthetics and corticosteroids have been used extensively via Patient Group Directions (PGDs) by injection therapists, who are now estimated to number around 3,000 in the UK. PSDs, PGDs and, increasingly, Supplementary Prescribing are used in a broad range of community and acute settings. Physiotherapists use these mechanisms with a range of relevant medicines in clinical areas spanning musculoskeletal, pain management, neurological, respiratory, emergency, women’s health, paediatric and elderly care.

4.4 Podiatrists have used medicines since before the 1968 Medicines Act. Since 1972 they have had the ability to access, supply, sell and administer a list of medicines via Exemption Orders under medicines regulations. This list was revised in 2006 following public consultation. It includes selected local anaesthetics, antifungals, analgesics, anti-inflammatory and antibiotics. The majority of nail and foot surgery conducted by podiatrists makes use of Exemptions and PGDs. Supplementary Prescribing is increasingly common in acute care and is used less commonly in community-based care of patients with lower limbs at increased risk of ulceration and/or amputation, for example those patients with diabetes and peripheral arterial disease or other immuno-compromised diseases.

4.5 Radiographers
Therapeutic radiographers constitute approximately 10% of the total membership of the radiography profession. However, they have taken up Supplementary Prescribing at a greater rate and currently about nine in ten radiographer supplementary prescribers are therapeutic. They use Supplementary Prescribing and PGDs to manage pain and other side effects of radiotherapy. Diagnostic radiographers constitute about 90% of the profession. A small number use Supplementary Prescribing and many more use PGDs for a range of medicines, such as analgesics and anti-emetics, which may be required before, during and after procedures. Contrast agents are generally managed via PSDs or PGDs.
4.6 Dietitians use PSDs or PGDs to supply a range of renal, obesity, pancreatic and diabetic drugs. A recent survey by the British Dietetic Association found PGD use in diabetes, nutrition support, renal disease, cystic fibrosis, gastroenterology and obesity. Dietitians also have a key role in advising other professionals on appropriate prescription in relation to changing nutritional status in a wide variety of conditions – in acute and community settings.

4.7 Speech and language therapists currently make use of PSDs and PGDs to supply and administer medicines to assist a variety of procedures, including video fluoroscopy, nasendoscopy, selection and fitting of tracheo-oesophageal valves. In a variety of other conditions, rather than delivering medicines, they play a key role in assessing and recommending to other prescribers the appropriate borderline substances, such as thickened feeds.

4.8 Occupational therapists make some use of PGDs in acute care settings such as walk-in centres and occasionally also in rheumatology to deliver corticosteroid injections. Much of their work involves management of long-term conditions, elderly care and mental health, which involves clinical pathways less suited to PGD use.

4.9 Orthoptists make extensive use of PGDs and PSDs to administer a variety of preparations to the eye, for both diagnostic and therapeutic purposes. They also make limited use of PGDs to assist the care of patients with glaucoma.

4.10 Prosthetists and orthotists predominantly treat NHS patients but are often employed by private companies, who are contracted to the NHS. Few (approximately 20%) are directly employed by the NHS. Although the mechanisms of PSDs and PGDs are available to the profession, there is no evidence that they have yet been used.

4.11 Arts therapists (art, music and dramatherapists) do not currently prescribe or supply medicines, nor do they perceive that their patients require it of them.
5. Challenges with the existing arrangements

5.1 A summary of prescribing and medicines supply mechanisms is provided at Appendix 5.

**Patient Specific Direction (PSD)**

5.2 This mechanism is available to all allied health professionals. It requires direct input from an independent prescriber (normally a doctor). Allied health professionals are autonomous practitioners and most work without immediate access to a doctor. Consequently, this mechanism does not necessarily meet the needs of patients in many of the settings in which allied health professionals work.

**Patient Group Direction (PGD)**

5.3 Local approval of a PGD can involve some delay while relevant governance is put in place. Drug storage issues can arise and some services may require new storage facilities. Clinicians report variable success in implementing PGDs; there are examples of good practice but their use is not universal. PGDs are designed for supply and/or administration of medicine for short-term care, and are not usually appropriate for patients requiring ongoing care. While a single dose or course of medicine may be appropriate in some settings, in other cases the patient will need ongoing supply and will therefore need to see a prescriber for this.

5.4 PGDs do not allow the holistic medicines management that many patients need, for example stopping one previously prescribed medication in order to supply another more appropriate drug, as may be required when modifying a patient's analgesia.

5.5 In some clinical settings, the number of PGDs required makes the mechanism difficult to implement and impractical to administer. For example in the management of back pain, an allied health professional would require a PGD for analgesics, a PGD for non-steroidal anti-inflammatories and a PGD for pain-modulating preparations (low-dose tricyclic antidepressants, gabapentin and pregabalin). As many organisations require each drug to be on a separate PGD, over ten PGDs may be needed to manage this condition.

5.6 A number of allied health professions use PGDs successfully in acute or short-term care. However, allied health professionals’ caseloads often involve the multidisciplinary care of long-term conditions. PGDs are generally not appropriate in these pathways.
5.7 Exemptions for supply or administration of a named drug are used with variable frequency by podiatrists. Exemptions can create drug storage issues, particularly for services delivered in multiple or satellite locations, and their revision involves lengthy processes. They allow the podiatrist to supply a specific dose in a specific circumstance, which can sometimes be exactly what a patient needs. However, podiatry patients with diabetes, vascular disease or musculoskeletal conditions frequently require alternative preparations or more holistic medicines management, involving modification of existing drug regimes in addition to flexible prescribing of new preparations. The inflexibility of Exemptions hampers service development to improve patient care.

5.8 An example of an allied health profession with potential to make good use of Exemptions is orthoptists. The diagnosis and management of disorders of binocular vision require a limited number of specific drugs. These are used within the consultation, or supplied for short-term use, without the need to modify other preparations. Currently orthoptists supply these preparations via PGDs. This generates significant work locally, which is replicated across the country. Exemptions may provide a more efficient mechanism.

5.9 Supplementary Prescribing requires a link with a doctor to approve a clinical management plan (CMP) for the individual patient. In 1999, the Review of Prescribing, Supply and Administration of Medicines by Dr June Crown CBE\textsuperscript{16} noted the competence and autonomy of podiatrists and specialist physiotherapists and recommended them, along with nurses and optometrists, for early implementation of Independent Prescribing. Experience now demonstrates that Supplementary Prescribing lacks compatibility with the needs of many patients under the care of physiotherapists and podiatrists.

5.10 Doctor availability for CMP agreement poses the greatest challenge for physiotherapists, podiatrists and radiographers, who frequently work in clinical settings in which a doctor is not present. Similar difficulties have been cited in the nursing literature.\textsuperscript{17} Other problems reported by allied health professionals and reflected in the literature include uncertainty regarding who the independent prescriber should be\textsuperscript{18} and difficulties when timeframes of care are short, such as short stays in hospital or one-off outpatient appointments.\textsuperscript{19}


5.10.1 As nurses and pharmacists have previously found, implementation of Supplementary Prescribing is dependent on close working relationships with doctors. Most physiotherapists and podiatrists work autonomously and remotely from medical practitioners. Their referral pool frequently includes numerous GP surgeries or geographical areas. It is not possible to develop close individual working relationships with such a potentially large number of doctors.

5.10.2 Nurses now use Supplementary Prescribing much less frequently than Independent Prescribing, partly due to difficulty in implementing the CMP.

5.10.3 Many nurse prescribers work in general practice. In contrast, many podiatrists, and physiotherapists work in community settings in which pharmacists and some nurses have already experienced difficulties in implementing Supplementary Prescribing.

Interpretation of Supplementary Prescribing

5.11 Allied health professionals using Supplementary Prescribing report implementation difficulties due to ambiguity surrounding the legal boundaries of Supplementary Prescribing.

5.11.1 Issues surrounding assessment and diagnosis: The official guidance states (paragraph 19):

“Supplementary Prescribing may only take place after a specified point in the individual patient episode, i.e. after assessment and diagnosis by an independent prescriber and the development of a written CMP agreed between the independent and supplementary prescriber.”

However, allied health professionals are frequently responsible for patient assessment, investigation and diagnosis. Consequently, the doctor will often agree a diagnosis that has been made by the allied health professional. This may be done remotely, without the doctor seeing the patient. Different organisations appear to interpret the guidance in different ways.

5.11.2 It may not be clear which doctor should be the independent prescriber in the Supplementary Prescribing partnership. The guidance states (paragraph 18):

“The independent prescriber should be the clinician responsible for the individual’s care at the time Supplementary Prescribing is to start.”

However, an allied health professional may be the clinician who is responsible for the patient’s care, as is the case in consultant allied health professional-led services.

5.11.3 Two further areas of ambiguity exist, in which the line of accountability and responsibility is less clear within the context of Supplementary Prescribing:
> when the GP has discharged responsibility by referring the patient to a medical consultant but local pathways divert that referral to an allied health professional without having been reviewed by that medical consultant; and
> if the allied health professional enters a prescribing partnership with a doctor, such as a specialist GP, who may not have seen the patient or have any other responsibility for them.

5.11.4 A third example relates to the duration of the condition. Supplementary Prescribing was intended for use between medical reviews in the management of long-term conditions. A medical review should be conducted at least annually. Allied health professionals have used Supplementary Prescribing for patients whose condition is diagnosed and treated, and the patient discharged, by the allied health professional without the need for medical review.

Clinical examples

5.12 A number of clinical examples are provided at Appendix 6 to illustrate some of the issues identified in this and following chapters. In addition, further clinical examples are provided throughout this report to illustrate specific points. These examples are not intended as a definitive list for each profession.

Conclusions

5.13 The existing prescribing and medicines supply mechanisms are valuable tools, when used in appropriate pathways. It is incompatibility between the mechanism and the needs of patients that creates implementation difficulties. Increased access to prescribing and medicines supply mechanisms for some allied health professions may better align the needs of patients with the care they receive. More specific guidance on the implementation of Supplementary Prescribing could also be helpful.
6. Quality – patient safety

6.1 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.

Existing safety record

6.2 The Patient Safety Observatory\(^{21}\) reported 60,000 medicines incidents across the NHS between January 2005 and June 2006, including 92 cases of severe harm or death, with an estimated cost to the NHS in England of over £750 million annually. Although the number of trained allied health professional prescribers in this period was low, nurse, pharmacist or allied health professional prescribers were not identified as being responsible for any of these incidents.

6.3 No serious incidents or case law relating to AHP medicines use have been reported to this project. The Medical Defence Union reported to the project that they are aware of no particular problems relating to prescribing or medicines supply by allied health professionals. This is not currently an area of concern raised by Medical Defence Union members.

6.4 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.

Potential to improve safety

Reducing delays

6.5 Avoidable delays in patient care occur when an allied health professional 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. To mitigate risk, allied health professionals take alternative and sometimes costly action: calling an ambulance, sending the patient to A&E, or contacting a GP out-of-hours service. Greater AHP access to prescribing and medicines supply mechanisms could enable some allied health professionals to promptly deliver the care that is needed, thereby avoiding safety risks and the costs of delaying care.

6.5.1 Timely administration of appropriate antibiotics has been shown to reduce hospital admissions and the risk of limb-threatening infection in people with diabetes. The existing arrangements for community podiatrists 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.

6.5.2 Occupational therapists report examples of delays in the management of mental health patients in residential care and community settings. At times when an occupational therapist is both available and able to diagnose and manage an emerging situation, deterioration and safety risk could be avoided with better access to medicines.

6.5.3 Speech and language therapists diagnose swallowing disorders and determine whether patients need thickened fluids and medicines, yet they are unable to prescribe those same substances. Instead, patients must wait until the speech and language therapist can contact an independent prescriber, usually the patient’s GP, who may then prescribe as recommended. During this delay, patients can aspirate, sometimes resulting in an emergency hospital admission.

Improve the use of medicines

6.6 Specialist allied health professionals help the multidisciplinary team to tailor medicines to patients’ needs. When a clinical pathway supports Supplementary Prescribing, allied health professional supplementary prescribers are able to tailor care to improve effectiveness and safety. When the clinical pathway does not support use of Supplementary Prescribing, patients are unable to benefit.

6.6.1 Many physiotherapists are well placed to make timely reductions in analgesic preparation and/or dose as a patient responds to physical treatment, thereby reducing the risk of drug dependency. Similarly, non-steroidal anti-inflammatory drugs, which have documented gastrointestinal and cardiovascular risks, can be reduced as a patient responds to physical intervention and self-management.

6.6.2 Some podiatrists have specialist knowledge in the antibiotic management of infected foot ulcers, often complicated by osteomyelitis. They can ensure optimal prompt antibiotic therapy, supported by regular careful monitoring, reducing the risk of further complications and the potential for limb loss.


Clear clinical responsibility

6.7 All allied health professions (except music therapy, art therapy and dramatherapy) reported situations in which they were expert in a clinical condition or intervention, and the professional most familiar with the clinical case, yet were placed in the position of advising an independent prescriber in respect of a prescription. Such practice was a concern for nurses, leading to the instigation of nurse prescribing following the Cumberlege Report of 1986 and the Review of Prescribing, Supply and Administration of Medicines, led by Dr June Crown CBE in 1999. Greater prescribing flexibility would enable allied health professionals to take appropriate responsibility for their decisions.

Safety considerations

6.8 Section 3 outlines the professions and individuals involved in this early scoping project. As yet, no significant concerns have been identified regarding the potential advancement of prescribing and medicines supply for specific AHPs.

Training

6.9 Allied health professionals are highly trained, autonomous professionals. Appendix 4 gives an overview of the education and training that allied health professionals receive. Different AHPs receive different levels of pharmacology and medicines training at undergraduate level. Many receive additional specific pharmacology and medicines safety training as part of their postgraduate training. Allied health professionals wishing to prescribe must first gain entry to, and then pass, an approved non-medical prescribing training programme.

6.10 The Project Board concluded that, in principle, variability of pharmacology and medicines training prior to entering a non-medical prescribing training course posed no foreseeable safety risk to expansion of prescribing for AHPs. Prescribing competence consists of many factors, and individuals from all professions (nurses, pharmacists, optometrists and allied health professionals) begin prescribing training with different skills and expertise. Some groups (in particular the AHPs) start with greater skill in the independent diagnostic assessment of patients. Others (in particular pharmacists) begin with greater pharmacological knowledge. The focus of the prescribing training is safe and effective prescribing practice.

6.11 In order to gain entry to a prescribing training programme, allied health professionals (currently physiotherapists, podiatrists and radiographers) must already be highly advanced or expert in their clinical field, and their employing organisation must have identified a Supplementary Prescribing role for them to undertake once they have completed the training. Allied health professional supplementary prescribers currently undertake the same prescribing training as nurse and pharmacist independent prescribers. Whether the expansion of allied health professional prescribing would create any unique training needs would need to be considered in later work. This project has received no indication that this would be the case. It is also notable that the majority of nurse prescribers report that the training met their needs and prepared them for prescribing practice.

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Communication of prescribing

6.12 Access to, and updating of, the shared medical record is essential to the safety of all prescribing practice. As with nurses and pharmacists, the challenges this poses for remote working must be carefully considered. Until a fully functioning electronic NHS record is available, allied health professionals will need to continue as they and other professions do currently, using a variety of methods to ensure that they have access to the appropriate patient record and that the record is kept up to date. There is no evidence that AHP working environments create any unique challenges.

Professional governance and private practice

6.13 A number of individuals from each of the allied health professions undertake work in the private sector. Some are employed by private providers, some are self-employed, some are not employed by the NHS but are contracted to provide services for NHS patients. Many of the allied health professionals who undertake private sector work simultaneously hold a substantive NHS post. The precise number of individuals within each of these categories in England is not known. The professional bodies have provided estimates of the percentage of members involved in some form of private sector work (Table 2). For comparison, the latest data on NHS whole-time equivalents has also been included.

Table 2. Estimate of allied health professionals engaged in private sector work

<table>
<thead>
<tr>
<th>Profession</th>
<th>NHS (England) 2008 (headcount)</th>
<th>Health Professions Council (UK) 2008 (headcount)</th>
<th>Estimated % undertaking private sector work solely or in addition to an NHS post (UK) 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapy</td>
<td>21,114</td>
<td>42,095</td>
<td>35%</td>
</tr>
<tr>
<td>Podiatry</td>
<td>3,843</td>
<td>12,519</td>
<td>50%</td>
</tr>
<tr>
<td>Radiography</td>
<td>15,636</td>
<td>25,173</td>
<td>10%</td>
</tr>
<tr>
<td>Dietetics</td>
<td>3,749</td>
<td>6,582</td>
<td>8%</td>
</tr>
<tr>
<td>Speech and language therapy</td>
<td>7,115</td>
<td>12,038</td>
<td>6%</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>17,345</td>
<td>29,701</td>
<td>2% (not including those who also hold a substantive NHS or social services post)</td>
</tr>
<tr>
<td>Orthoptics</td>
<td>1,741</td>
<td>1,276</td>
<td>28%</td>
</tr>
<tr>
<td>Prosthetics and orthotics</td>
<td>Most not directly employed by NHS</td>
<td>869</td>
<td>80% (employed by private sector companies but most individuals work in the NHS)</td>
</tr>
</tbody>
</table>
6.14 All allied health professionals are regulated by the Health Professions Council and are subject to professional codes of conduct developed with the professional bodies. As with other professionals, they are also subject to the criminal and civil legal system. All of these professional accountabilities exist regardless of the work setting. Clinical governance will be an element of the regulatory requirements for services under the Care Quality Commission. The expansion of prescribing in professions working in the private sector requires consideration of the governance arrangements, but this is not unique to AHPs.

Conclusions

6.15 Greater access to prescribing and supply of medicines by allied health professionals has potential to reduce treatment delays, improve the specificity and responsiveness of prescribing and thereby reduce patients' exposure to safety risks. An additional benefit is the creation of clearer lines of clinical responsibility in prescribing.

6.16 Safety considerations associated with expansion of AHP prescribing and/or medicines supply mechanisms pertain to the training arrangements, communication of prescribing practice and governance arrangements – particularly in the private sector. These considerations are not unique to AHPs.
7. Quality – patient experience

7.1 The results of a large public consultation, reported in *Your health, your care, your say: Research report*[^26] and contained within *Our health, our care, our say: A new direction for community services*[^27] are reflected today in local commissioning strategies across the country. Patients want a high-quality, responsive, dignified and equitable NHS service, delivered conveniently and with choice.

**Access**

7.2 Allied health professionals deliver many innovative services, improving access, choice and convenience. Some examples include physiotherapy self-referral schemes, podiatry-led high-risk foot protection teams and vascular triage services, dietetics obesity management, occupational therapy vocational support and mental health case management, speech and language therapists working with language delay in early school children, combined physiotherapy and occupational therapy teams supporting patients at home to prevent emergency admission to hospital.

7.3 Some of these innovative services make use of the existing mechanisms to provide patients with greater access to medicines. For example, many physiotherapy-led musculoskeletal services provide intra-articular injections via Patient Group Directions. However, allied health professionals have the potential to further improve access and thereby empower patients to make their own choices about health and healthcare. Greater AHP medicines prescribing and supply flexibility could:

> improve access to medicines for patients of existing AHP services. Patients often access AHP services between visits to their GP or hospital doctor. Some allied health professionals lead patient care, as is the case in podiatry-led vascular triage and physiotherapy-led musculoskeletal services. Independent Prescribing or Supplementary Prescribing for certain AHP groups would allow patients faster access to new prescriptions and accessible advice regarding dose alteration and concordance with existing medicines;


make innovative and convenient AHP services available to more patients. Under the present arrangements, patients who perceive a need for medicines advice or prescribing must choose alternative or additional providers. 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, prescribing nurse or prescribing pharmacist instead of, or in addition to, the physiotherapist; and

> provide infrastructure that would enable frontline staff to lead change for patient benefit. Independent Prescribing for certain AHP groups would permit greater innovation in providing comprehensive care closer to home. Supplementary Prescribing for some groups enables greater partnership between doctors and allied health professionals, facilitating greater outreach of hospital and primary care services.

Convenience

7.4 Patients want to avoid the inconvenience of multiple appointments with duplication of travel, hospital parking and time off work. AHP services could improve convenience for patients through extending access to medicines.

7.4.1 Patients would need to make fewer additional trips to the doctor in order to manage their medicines. In the future, patients with arthritic or musculoskeletal conditions could utilise personal budgets to self-refer to AHP services (such as physiotherapy) and receive a one-stop service that manages their diagnostic, physical and medicines needs. This would complement GP and/or hospital care, by allowing many patients greater convenience and greater self-determination.

7.4.2 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. This would streamline services and require patients to take less time off work. For example, a glaucoma patient attending outpatients could often have all their needs addressed by the orthoptist, if the orthoptist were able to prescribe. This is in line with NICE draft guidelines,28 which recommend consultant-led care, delivered by appropriate professionals between consultant review. It would also enable local development of innovative community care.

Choice

7.5 Local clinical leaders currently lack the freedom to focus on quality, as the limitations of the existing arrangements (see Section 5) must be accommodated in service design:
> Service design is limited to the boundaries of the existing mechanisms. This stifles innovation, thereby reducing choice for patients and commissioners.
> Services are commissioned less efficiently. Additional steps are created in care pathways to accommodate prescribing, and additional staff are required to deliver those steps.

7.6 Expansion of prescribing and medicines supply supports the principle of subsidiarity, by enabling the workforce greater freedom to develop patient-centred services in new and innovative ways, including social enterprise models. This creates greater choice for patients and commissioners.

Reducing inequalities

7.7 Extending access to medicines to traditionally hard-to-reach populations through enhanced AHP services has potential to reduce health inequalities. Elderly, disabled, traveller and ethnic minority groups are likely to benefit from enhanced, more accessible and responsive services being offered closer to home.

Conclusions

7.8 Extension of prescribing and medicines supply for certain AHP groups would improve the patient experience, by allowing patients greater access, convenience and choice.
8. Quality – effectiveness

8.1 Effectiveness refers to the outcomes of clinical care, avoidance of ill health and helping people to stay healthy. Under the present arrangements, the existing mechanisms are used by individuals from the majority of allied health professions to improve the effectiveness of patient care. Some examples for each profession are outlined in Section 4.

8.2 The extent to which the existing arrangements promote effective care varies according to the clinical pathway:

> In some cases, the existing mechanisms enable highly effective care. For example, a podiatrist performing nail surgery in the community can use Exemptions to administer local anaesthetic for surgery and, if necessary, can use some antibiotics to treat an uncomplicated local infection.

> Dietitians improve treatment effectiveness through concurrent use of diet and PGDs, for example in the control of phosphate levels in patients with chronic kidney disease, reducing ill health arising from bone destruction.

> However, in many cases the existing mechanisms do not allow optimal effectiveness. This is demonstrated by podiatric management of diabetic foot infections. Exemptions lack sufficient breadth or flexibility of antibiotic supply to deliver the best evidence-based care to patients with deep infection, osteomyelitis and complex co-morbidity. PGDs are not normally appropriate due to the breadth of possible medicines required and the ongoing nature of the condition. Supplementary Prescribing is not suited to one-off episodes of care, particularly as the allied health professional is assessing, diagnosing and independently managing the patient. When Supplementary Prescribing is attempted, the time taken for the agreement of the clinical management plan risks the worsening of infected wounds, leading to greater clinical risk, potentially avoidable hospital admission and possible amputation. Consequently, the supplementary prescriber must take alternative and potentially costly action, such as an A&E referral.
Allied health professionals lack the tools to provide best patient care

8.3 In numerous clinical pathways, allied health professionals now deliver care that was previously provided by doctors, or work collaboratively across traditional boundaries:
> Podiatrists undertake surgery and lead multidisciplinary community-based foot protection teams, who respond to the needs of patients with high-risk lower-limb pathology, often without medical intervention.
> Physiotherapists see self-referred patients, independently manage orthopaedic and rheumatology referrals in musculoskeletal assessment and treatment services, and lead outpatient review clinics in neurology, women’s health and respiratory care.
> Diagnostic radiographers undertake invasive diagnostic procedures.
> Therapeutic radiographers lead radiotherapy care and reviews without on-site medical back-up.

8.4 In these clinical pathways, investigations, therapeutic procedures and appropriate onward referral can occur as it would in medically led care. Prescribing of medicines is the only aspect of care that patients are unable to receive as they would from an independent prescriber. Consequently, provided that there is no risk to safety, allied health professionals deliver high-quality care but this is often in the absence of optimal medicines management. 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.

Potential to improve effectiveness further

Improving adherence to medicines

8.5 An allied health professional is often the multidisciplinary team member with whom the patient spends the most time. Appointments may last 30–60 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, 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.

8.5.1 This principle applies to all allied health professions, for example:
> a physiotherapist treating back pain;
> a dietitian seeing a patient for obesity management;
> a speech and language therapist treating an oncology patient;
> a radiographer delivering radiotherapy; or
> a podiatrist triaging a patient with suspected peripheral arterial disease.

8.5.2 In all these examples, greater flexibility of prescribing would allow the allied health professional to contribute more towards better long-term medicines use.
8.5.3 The potential to widen the effectiveness of patient care may be achieved without change to existing pathways. Some existing pathways in which patients could immediately benefit from Supplementary Prescribing include orthoptists working with glaucoma patients, where National Institute for Health and Clinical Excellence (NICE) draft guidance recommends consultant-led care, with community or clinic care managed by other professionals. Other pathways include occupational therapists working as care coordinators in mental health, speech and language therapists working with stroke patients and dietitians working with patients who have renal disease. In each of these long-term condition examples, allied health professionals already lead community or outpatient review clinics and provide care between medical reviews. Supplementary Prescribing would enable greater responsiveness and flexibility of care.

Specialist care

8.6 Many allied health professionals are expert in their area of work. Expanding the delivery of medicines would enable them to improve the effectiveness of care for their patients. This principle applies to individuals from a variety of allied health professions. For example, podiatrists working at specialist or consultant level in diabetic or vascular foot care are expert in evidence-based delivery of aggressive antibiotic treatment of ulcers in the community. With a growing diabetic population in the UK and a high rate of amputations in this population, effective frontline care in the community is essential in order to treat disease and prevent ill health. Similarly, dietitians are expert in the adjustment of obesity and diabetic medications in line with nutrition; specialist women’s health physiotherapists are expert in the use of antimuscarinics to assist treatment of bladder dysfunction; and diagnostic radiographers are expert in drug interactions with imaging contrast media. This principle applies to many allied health professions, as each has individuals working in highly specialised roles.

Reduced sickness absence

8.7 The timely combination of physical and pharmaceutical treatment by allied health professionals has the potential to reduce inequalities, improve clinical outcomes and return people to work faster. For example, a physiotherapist directing physical rehabilitation and return to work for a patient with back pain can be more effective if they can fine-tune medications and dosage to complement physical gains and to support rehabilitation. They may reduce the dosage of a neuropathic pain modulator such as amitriptyline or gabapentin to control the side effect of morning drowsiness as a person returns to work. They may modify anti-inflammatory or analgesic dosage while increasing muscular endurance in the early stages of return to work. This degree of medication specificity is currently difficult to achieve, as a patient has to go to and fro between their physiotherapist and their GP and/or medical consultant to communicate their needs.

29 Ibid.
8.8 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).\(^{31}\) In contrast, allied health professionals play key roles within innovative rehabilitation schemes and the national Condition Management Programme. Allied health professionals apply a biopsychosocial and self-directed approach to work injury rehabilitation. Increasing the flexibility with which allied health professionals prescribe and supply medicines as part of this has the potential to improve treatment effectiveness and thereby improve the health of the workforce.

**Combining pharmaceutical and AHP care**

8.9 Paragraphs 6.5 and 6.6 demonstrate how allied health professionals can improve the timely delivery of medications in line with patients’ evolving rehabilitative state, to improve safety. These examples also demonstrate that allied health professionals could improve the effectiveness of care. Similarly, with greater prescribing flexibility, dietitians could modify drug regimes in a timely manner to complement the dietary changes that their patients are making. Currently, patients have to see another professional for prescribing changes, decreasing the responsiveness and effectiveness of care.

8.10 Many allied health professionals could improve the effectiveness of care with fast access to medicines. Some examples include:

> oral thrush agents to assist care in speech and language therapy;
> agents to control the pain and vomiting that are side effects of radiotherapy;
> agents to control bronchospasm in respiratory rehabilitation settings;
> adequate post-operative pain control in physiotherapy rehabilitation, as it influences surgical outcomes;
> neurological physiotherapists and occupational therapists titrating the use of tone-reducing agents to treat spasticity alongside stretching and serial casting;
> dietitians working with children suffering from cystic fibrosis to appropriately match their dietary fat intake with the type and dose of prescribed pancreatic enzyme replacement therapy. Supplementary Prescribing fits well with the needs of these children, who are managed by the dietitian between medical consultations; and
> podiatrist-led clinics, which manage painful foot neuropathy and provide interventions ranging from acupuncture to the use of Supplementary Prescribing to deliver appropriate pain relief where possible.

In all these scenarios, the effectiveness of AHP treatment can be enhanced when the allied health professional responsively directs pharmaceutical input. The existing prescribing and medicines supply mechanisms go only part of the way to providing a practical solution in many of these pathways.

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Reduced delays in care

8.11 Improved effectiveness can result from reducing delays in care. Paragraph 6.5 provides some examples, emphasising the safety perspective, but in all such examples delays can also reduce the effectiveness of patient care.

Potential to reduce ill health and help people to stay healthy

8.12 In keeping with the principles of transforming healthcare, allied health professionals are already recognised as key professionals in the delivery of lifestyle-based, self-managed care for the prevention and management of many long-term conditions. If greater prescribing flexibility was available to physiotherapists and podiatrists, patients could receive more comprehensive care via new roles and new ways of working by allied health professionals, such as physiotherapy self-referral, community hospital-based high-risk foot protection teams, and dietitian-led interventions for a range of conditions.

8.13 The potential for greater effectiveness through the prevention of ill health exists in many AHP services, across the spectrum of condition chronicity. A patient requiring speech therapy may need a prescription for oral thrush medications or borderline thickened fluids in long-term neurovascular conditions. A patient undergoing therapeutic radiography may unexpectedly need a supply of medication to relieve short-term nausea or pain associated with radiotherapy.

Conclusion

8.14 While the existing arrangements have helped to improve the effectiveness of care for some patients, there is potential for allied health professionals to contribute much more. Providing an increased ability for allied health professionals to prescribe and supply medicines would quickly allow existing care pathways to offer more effective care. It would also future-proof the NHS with a flexible frontline workforce that is capable of leading the development of innovative new care pathways for the benefit of patients.
9. Value for money and productivity

9.1 The existing mechanisms enable some services to provide greater value for money than they otherwise could. The benefit is greatest when the mechanism allows supply in a manner well suited to the needs of patients in an existing service. In such cases, there are several cost-efficiency savings:

- Allied health professionals can offer more comprehensive care, by also prescribing or supplying medicines.
- By offering this more comprehensive service, they make greater choice available to patients and commissioners, contributing to the creation of system-wide value.
- There is reduced duplication of care, as a patient does not have to see another professional, or another service, in order to receive their medicine(s).
- The AHP service often has a lower unit cost than the alternative provider. This is especially true when the alternative is secondary care.
- The cost to the patient is reduced, for example because they take less time off work.

9.2 For all AHP services that use the existing mechanisms, the first four points above apply to greater or lesser degree. In some cases, the cost saving per case may be substantial – for example, when podiatrists perform nail or foot surgery in a community setting. In other cases, the payment-by-results unit cost may be unchanged but improved service efficiency adds to overall value for money. An example of this would be orthoptists using PGDs to administer medicines to the eye for diagnostic purposes in an ophthalmic department.

Changes could further improve productivity

9.3 Currently, allied health professionals are only able to add a proportion of the increased value of which they are capable. Further productivity savings could be made if allied health professionals were able to prescribe and supply medicines with greater flexibility.

9.3.1 All services using a PGD must absorb the administrative burden of developing and maintaining the PGD. As described in Section 5, PGDs and Exemptions are limited in that they only allow patients to receive a short-term supply of a medicine. In cases where a patient requires adjustments to other medicines or repeat supply of a new medicine, they must see an independent prescriber in addition to the allied health professional. With changes to legislation, allied health professionals could prescribe within their area of competence and remove the need for duplication of care.
9.3.2 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); and
> 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.

### Reduced resource usage – fewer appointments

9.4 Independent Prescribing by allied health professionals could result in the need for fewer appointments with other professionals. For example:

9.4.1 A&E attendance and admissions for unscheduled care could be reduced.
> Currently, many patients facing delays in receiving antibiotics from community podiatrists will attend A&E.
> Minor fluctuations in parameters such as blood pressure during podiatric surgery could be safely managed by the podiatrist, avoiding the need for A&E attendance.

9.4.2 Some patients’ medication needs could be met by the allied health professional 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 24% of patients who self-referred to physiotherapy required a prescription for their condition, which suggests that there is potential for large reductions in GP 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.

9.4.3 Secondary care departments and wards could become more efficient. Physiotherapists and podiatrists 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 elderly care settings. Radiographers could manage unexpected side effects of radiotherapy or diagnostic procedures, needing to call on medical colleagues only if clinically appropriate.
9.5 Supplementary prescribing by allied health professionals who are already leading outpatient care and caring for patients between medical reviews would further save independent prescribers time. Examples include orthoptists working with glaucoma patients, occupational therapists working as care coordinators in mental health, speech and language therapists working in head and neck oncology and dietitians working in diabetes, gastroenterology or renal disease.

**Reduced resource usage – fewer prescriptions**

9.6 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 allied health professionals 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.

9.6.1 The physiotherapy self-referral pilots included 2,835 patients. Of these, 38% 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.32

9.6.2 Information from allied health professional-led specialist services suggests that prescribing physiotherapists often use Supplementary Prescribing to alter or stop existing medications and less frequently prescribe 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.33

9.6.3 Oral nutritional supplements (ONS) are not prescription-only medicines and as such can be purchased privately or supplied through local arrangement, by any healthcare professional. They are often prescribed as borderline substances. The use of ONS incurs significant costs to the NHS. In London alone, the cost of adult ONS was just under £13 million for the year 2007/08, and it was estimated to be about £80 million nationally.\textsuperscript{34} Local audit data indicates that a number of ONS prescriptions are initiated without clear indications, with up to 75% of patients receiving ONS inappropriately. Initiatives such as the use of a demand management dietitian are recommended. As ONS can be supplied by non-prescribers, this does not clearly create a case for prescribing by dietitians. However, it does demonstrate that reduced ONS prescribing may result from dietitian involvement in prescribing decisions.

Locally led service enhancement

9.7 Changes to the legislation would enable local commissioners and providers to develop the AHP workforce and local services to meet the needs of patients in the most cost-effective way. Currently, new service developments, such as relocation into community settings or innovative pathway redesign, must accommodate additional Independent Prescribing staff and/or additional administration time to support CMP organisation in Supplementary Prescribing. This creates a unit cost which is inflated, predominantly in order to accommodate patients’ medicines needs. The cost could be reduced with greater flexibility of AHP prescribing.

Cost considerations

Training

9.8 The primary cost of any expansion to AHP prescribing and medicines supply mechanisms would be training. The cost per head of a prescribing training course is between £1,000 and £1,500, which is currently met by the strategic health authority. 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.

9.9 A small number of additional hours may be needed, in order to train existing supplementary prescribers as independent prescribers. Further work would be needed to consider whether such a conversion were necessary for AHP supplementary prescribers and the content of any additional training.

9.10 Although numbers are increasing, uptake of Supplementary Prescribing among allied health professionals has been slow. The main reasons for this have been the following:
> After legislative change enabling Supplementary Prescribing for physiotherapists, podiatrists and radiographers in 2005, there were delays in the accreditation of training courses.
> Many physiotherapists and podiatrists work in roles that are incompatible with Supplementary Prescribing.
> In order to ensure succession planning, continuity of patient care and capacity to deliver new services, many therapeutic radiography services had to delay and carefully plan release of staff for the training. This was not unique to allied health professionals, as similar issues were encountered in the early stages of nurse prescribing.

9.11 In the early stages of non-medical prescribing development, the uptake rate among nurses was particularly important due to its impact on the economic viability of training programmes. This is no longer a key issue, as training programmes are now established across England. These programmes are multidisciplinary and are easily accessible to allied health professionals.

Research

9.12 There are early indications that prescribing by some allied health professionals could positively impact on resource usage and prescribing costs. Understanding of this would be enhanced by further evaluation or research. Currently, there are examples of local service evaluation and audit, but there has not yet been any published quantitative research in these areas. Further work should give consideration to the commissioning of research into AHP prescribing, in a similar manner to that which has accompanied the expansion of nurse and pharmacist prescribing.

Conclusion

9.13 There is potential to improve the efficiency of service delivery and value for money by permitting greater flexibility of prescribing and medicines supply by selected professions. There is a negative cost implication to maintaining the status quo because service efficiency and innovation are currently hampered by incongruence between the existing mechanisms and patient need. It is likely that savings made will outweigh training costs.
10. Conclusions

General conclusions

10.1 Allied health professionals play a key role in contemporary clinical pathways and currently have access to a complex mix of prescribing and medicines supply mechanisms. To date, their use of these mechanisms has been safe and to the benefit of patients.

10.2 In some clinical pathways, the existing arrangements support optimal patient care. Allied health professionals should be encouraged to make the best use of the mechanisms available to them. In particular, prosthetists and orthotists should be encouraged to improve their service to patients by exploring the use of PGDs.

10.3 When medicines are involved, the care that patients receive can be limited by a lack of AHP access to the most appropriate prescribing and medicines supply mechanism. It is not in the best interests of patients for clinical pathways to be made to fit the current prescribing and medicines supply mechanisms; rather, the availability of the mechanisms to healthcare professionals should reflect the needs of their patients.

10.4 The role of allied health professionals is not yet adequately reflected in medicines legislation. Further work is necessary to better align the prescribing and medicines supply mechanisms available to allied health professionals with the needs of patients.

10.5 Revision of the mechanisms available to allied health professionals is necessary in order to meet patient need, allow development of the professional workforce and enable local development of contemporary healthcare services.

10.6 There is some local service evaluation and audit data surrounding AHP prescribing, but little qualitative or quantitative research has been conducted.

10.7 Patient safety is paramount – safety considerations associated with extending AHP prescribing pertain to ensuring the safe knowledge and use of medicines, the development of appropriate training and appropriate governance arrangements for NHS and private sector settings. These issues are not unique to AHPs.

10.8 The allied health professions have different roles and variable experience in the safe and effective use of medicines. The case for change is different for each profession. This difference should be reflected in any future work.
10.9 Differences also exist within professions. A single mechanism will not meet patient need in all pathways for any profession. This creates a dichotomy regarding the best model for extending non-medical prescribing:

> in keeping with the existing profession-based model: appropriately trained members of the same profession have access to the same mechanisms, with the risk that isolated clinical pathways or new practice may not be accommodated; or

> on the basis of patient need, irrespective of which professional group their caregiver is part of. This implies that all appropriately expert and trained individuals of any profession would have access to all mechanisms.

To date, all non-medical prescribing professions (except nurses) have gained the right to Supplementary Prescribing in the first instance. (Nurse prescribing was introduced before Supplementary Prescribing was available.) The current incremental approach has a proven track record of safety and should be maintained.

**Profession-specific conclusions**

**Physiotherapists**

10.10 On the basis of safety, patient experience, effectiveness and value, there is a strong case in support of progression to Independent Prescribing. Physiotherapists have demonstrated safe and effective use of all existing mechanisms available to date. Independent Prescribing is the most appropriate mechanism for patients in many physiotherapy care pathways, particularly those that involve first contact, diagnostic, self-referral and community care.

**Podiatrists**

10.11 On the basis of safety, patient experience, effectiveness and value, there is a strong case in support of progression to Independent Prescribing. Podiatrists have demonstrated safe and effective use of all existing mechanisms available to date. Independent Prescribing is the most appropriate mechanism for patients in many podiatry care pathways, particularly those that involve first contact, diagnostic, surgical and community care.

**Radiographers**

10.12 There is less evidence for progression to Independent Prescribing for radiographers than there is for physiotherapists and podiatrists. To date, small numbers of the profession (almost entirely limited to therapeutic radiographers) have demonstrated safe and effective use of Supplementary Prescribing. However, further work may later be needed to consider progression to Independent Prescribing for radiographers.
10.12.1 Therapeutic radiographers
Therapeutic radiography care pathways normally include a doctor (for example, at the time of diagnosis and/or referral for radiotherapy) and this provides opportunity for use of Supplementary Prescribing. Supplementary Prescribing often supports patient need in routine cases but cannot adequately accommodate unforeseen symptoms associated with radiotherapy treatment. It can also impact on productivity by placing additional requirements on doctors’ time.

10.12.2 Diagnostic radiographers
A much lower proportion of registered diagnostic radiographers are likely to need Independent Prescribing, as PGDs support patient need in many settings. However, in some pathways, particularly more invasive forms of diagnostic radiography, Independent Prescribing could better support patient need.

Dietitians

10.13 On the basis of safety, patient experience, effectiveness and value, there is a strong case for progression to Supplementary Prescribing. As dietitians do not yet prescribe, they have not had the opportunity to demonstrate safe prescribing practice. Dietitians safely make thorough use of the existing mechanisms available to them. They advise other professionals on prescribing and the adjustment of prescribing regimes in response to changing nutritional status for a variety of clinical areas including diabetes, gastroenterology, pancreatic disorders, renal disease, obesity and cystic fibrosis. Patients in many dietetic care pathways would benefit from Supplementary Prescribing. In some cases, Independent Prescribing and/or Exemptions for the supply/administration of specific medicines may best suit the needs of dietetics patients.

Speech and language therapists

10.14 On the basis of safety, patient experience, effectiveness and value, there appears to be a case for progression to Supplementary Prescribing. Speech and language therapists provide highly specialised care, predominantly for patients with long-term conditions. The majority of their patients’ needs are well suited to Supplementary Prescribing.

Occupational therapists

10.15 There is a less strong case in support of progression to Supplementary Prescribing. Based on the evidence available to this project, very few occupational therapists use the present mechanisms available to them. This may be explained by the incompatibility of those mechanisms with the needs of their patients. In areas such as mental health case management and crisis management, there is potential to improve patient experience, effectiveness and value for money through the use of Supplementary Prescribing.
Orthoptists

10.16 There is a strong case in support of Exemptions for the specific list of medications used in the diagnosis and treatment of disorders of binocular vision. The profession has a long history of safe and effective practice with these preparations and currently uses PGDs. In this area of practice, Exemptions would support optimal patient care and optimal service delivery. There may also be a case in support of progression to Supplementary Prescribing. This is particularly relevant to glaucoma care. Exemptions do not suit the needs of patients with glaucoma, as existing medications frequently need modifying as part of ongoing care. Supplementary Prescribing would be most appropriate for these patients.

Prosthetists and orthotists

10.17 This profession is not currently making use of the mechanisms available to it. There is some evidence that effectiveness of treatment and patient experience could be enhanced with medicines supply or administration by the prosthetist/orthotist. The profession’s lack of PGD use is attributed to poor awareness. There is no existing record of the safe and effective use of medicines in this group. Work to raise the awareness of PGDs in the profession could be beneficial to patients.

Art therapists, music therapists and dramatherapists

10.18 These professions do not perceive a patient or service need and there is no evidence that the prescribing or supply of medicines by these professions is required.
11. Recommendations

11.1 This project recommended to the Chief Health Professions Officer that the Department of Health's Non-Medical Prescribing Board be asked to consider further work towards the following recommendations in respect of prescribing and medicines supply mechanisms. These recommendations have been endorsed by the Non-Medical Prescribing Board.

11.2 It is not possible to pursue all these recommendations within the same timescale. The suggested prioritisation of work is based on clinical need in the context of the NHS reforms and will take into account Department of Health and Medicines and Healthcare products Regulatory Agency resources available.

11.2.1 Phase 1 – further work should be undertaken to establish:
> Independent Prescribing by physiotherapists;
> Independent Prescribing by podiatrists;
> Supplementary Prescribing by dietitians, and consideration of a specific list of potential Exemptions for dietitians; and
> a specific list of Exemptions for orthoptists.

11.2.2 Phase 2 – further work should be undertaken, when appropriate, to consider the need for:
> Independent Prescribing by radiographers;
> Supplementary Prescribing by speech and language therapists;
> Supplementary Prescribing by orthoptists; and
> Supplementary Prescribing by occupational therapists.

11.3 Consideration should also be given to supporting coordinated research into the impact of AHP prescribing on patients, services and prescribing trends. This research should be conducted alongside the development of practice and should not delay change.
# Appendix 1

## Project Board membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Karen Middleton</td>
<td>Chief Health Professions Officer, Department of Health</td>
</tr>
<tr>
<td>Shelagh Morris</td>
<td>Allied Health Professions Officer, Department of Health</td>
</tr>
<tr>
<td>Darryn Marks</td>
<td>Seconded Project Manager, Department of Health[^35]</td>
</tr>
<tr>
<td>Paul Robinson</td>
<td>Policy Lead, Non-Medical Prescribing, Department of Health</td>
</tr>
<tr>
<td>Maureen Morgan</td>
<td>Nursing Officer, Department of Health</td>
</tr>
<tr>
<td>Anne Ryan</td>
<td>Sales/Supply Policy and Freedom of Information Unit, Medicines and Healthcare products Regulatory Agency</td>
</tr>
<tr>
<td>Louise Stuart MBE</td>
<td>Consultant Podiatrist, Allied Health Professions Non-Medical Prescribing Lead, NHS North West</td>
</tr>
<tr>
<td>Amanda Allen</td>
<td>Strategic Health Authority Allied Health Professions Lead, NHS South East Coast</td>
</tr>
<tr>
<td>Gul Root</td>
<td>Principal Pharmaceutical Officer, Department of Health</td>
</tr>
<tr>
<td>Trudy Granby</td>
<td>Assistant Director, Prescribing Development and Support, National Prescribing Centre Plus</td>
</tr>
<tr>
<td>Dr Mark Williamson</td>
<td>Associate Director of Primary Care, Commissioning and System Management, Department of Health; Senior Medical Adviser Offender Health, Social Care Local Government and Care Partnerships, Department of Health; General Practitioner, HMP Hull and the Quays, Hull</td>
</tr>
<tr>
<td>Jane Nicholls</td>
<td>Non-Medical Prescribing Lead, NHS London</td>
</tr>
<tr>
<td>Dr Alan Borthwick</td>
<td>Allied Health Professions Federation Representative, School of Health Sciences, University of Southampton</td>
</tr>
<tr>
<td>Charlotte Urwin</td>
<td>Policy Manager, Health Professions Council</td>
</tr>
</tbody>
</table>

## Extended Project Board – 6 January 2009

### Additional attendees:

- Prof PG Wiles: North Manchester General Hospital, Pennine Acute Hospitals NHS Trust
- Prof Sue Latter: University of Southampton
- Anita Gay: Podiatrist, New Graduate Representative

[^35]: Darryn Marks is a consultant physiotherapist and Assistant Director of Therapies at Barnsley Primary Care Trust. He is also a supplementary prescriber.
Appendix 2

The allied health professions

Allied health professionals are a diverse group of clinicians who deliver high-quality care to patients and clients across a wide range of care pathways and in a variety of different settings.

Nearly 82,500 allied health professionals work in the NHS in England. Significant and increasing numbers work in other public services such as social care and education, and in the private and voluntary sectors.

Allied health professionals are graduates. From the point of registration they are autonomous practitioners.

All allied health professionals have four common attributes:

> They are, in the main, first-contact practitioners.
> They perform essential diagnostic and therapeutic roles.
> They work across a wide range of locations and sectors within acute, primary and community care.
> They perform functions of assessment, diagnosis, treatment and discharge throughout the care pathway – from primary prevention through to specialist disease management and rehabilitation.

The professions and their roles are as follows.

**Art therapists** provide a psychotherapeutic intervention that enables clients to effect change and growth by the use of art materials to gain insight and promote the resolution of difficulties.

**Chiropodists/podiatrists** diagnose and treat abnormalities of the foot. They give professional advice on prevention of foot problems and on proper care of the feet.

**Diagnostic radiographers** produce high-quality images on film and other recording media, using all kinds of radiation.

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38 Ibid.
39 Ibid.
**Dietitians** translate the science of nutrition into practical information about food. They work with people to promote nutritional well-being, prevent food-related problems and treat disease.

**Dramatherapists** encourage clients to experience their physicality, to develop an ability to express the whole range of their emotions and to increase their insight and knowledge of themselves and others.

**Music therapists** facilitate interaction and development of insight into clients’ behaviour and emotional difficulties through music.

**Occupational therapists** assess, rehabilitate and treat people using purposeful activity and occupation to prevent disability and promote health and independent function.

**Orthoptists** diagnose and treat eye movement disorders and defects of binocular vision.

**Paramedics** are ambulance service health professionals who provide urgent and emergency care to patients. They assess and treat patients before transferring or referring them to other services, as appropriate.

**Physiotherapists** assess and treat people with physical problems caused by accident, ageing, disease or disability using physical approaches in the alleviation of all aspects of the person’s condition.

**Prosthetists** and **orthotists**: prosthetists provide care and advice on rehabilitation for patients who have lost or who were born without a limb, fitting the best possible artificial replacement. Orthotists design and fit orthoses (calipers, braces, etc.), which provide support to part of a patient’s body to compensate for paralysed muscles, provide relief from pain or prevent physical deformities from progressing.

**Speech and language therapists** work with people with communication and/or swallowing difficulties.

**Therapeutic radiographers** treat mainly cancer patients, using ionising radiation and sometimes drugs. They provide care across the entire spectrum of cancer services.

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40 The work to take forward prescribing by paramedics is being done separately through the Emergency and Unscheduled Care Team at the Department of Health.
Allied health professional registration: the Health Professions Council

About the Health Professions Council

The Health Professions Council (HPC) is a statutory regulator and was set up to protect the public. To do this, the HPC keeps a register of health professionals who meet its standards for training, professional skills, behaviour and health.

Health professionals on the HPC register are called registrants. The HPC currently regulates the following (allied health professionals are highlighted in bold):

- arts therapists (art therapists, music therapists and dramatherapists);
- biomedical scientists;
- chiropodists/podiatrists;
- clinical scientists;
- dietitians;
- occupational therapists;
- operating department practitioners;
- orthoptists;
- paramedics;
- physiotherapists;
- prosthetists/orthotists;
- radiographers; and
- speech and language therapists.

The HPC was created by the Health Professions Order 2001. This sets out the role of the HPC and gives the HPC its legal power.

Health professionals must register with the HPC before they can use the protected title for their profession. This means that even if they have completed a course in, for example, physiotherapy, they will still not be able to call themselves a ‘physiotherapist’ unless they are registered with the HPC.

About registration

Registration shows that the health professional meets the HPC’s standards for their profession.

Registration exists to show the public that health professionals are fit to practise and that they are entitled to use the protected title for their profession. It shows that the practitioners on the HPC’s register are part of a profession with nationally recognised standards set by law.
Approving education and training programmes

The HPC’s role includes assessing education and training programmes against the standards that it sets. If a programme meets these standards, the HPC approves it and students who complete the programme are eligible to apply for registration with the HPC.

The Standards of Proficiency

The Standards of Proficiency are the standards that the HPC has produced for the safe and effective practice of the professions it regulates. They are the minimum standards that the HPC considers necessary to protect members of the public.

Registrants must meet these standards when they first register. After that, every three years as they renew their registration they will also be asked to sign a declaration that they continue to meet the Standards of Proficiency that apply to their scope of practice.

Registrants are required to undertake continuing professional development (CPD). If their scope of practice includes prescribing and supply of medicines, these aspects of their work should be included in CPD.

The Standards of Proficiency include both generic elements that apply to all HPC registrants and profession-specific elements that are relevant to registrants belonging to one of the professions that the HPC currently regulates.

The Standards of Proficiency play a central role in how registrants can gain admission to, and remain on, the register and thereby gain the right to use the protected title(s) of their profession. It is important that registrants read and understand this document. If a registrant’s practice is called into question, the HPC will consider these standards (and the HPC Standards of Conduct, Performance and Ethics) in deciding what action, if any, it needs to take.

Scope of practice

A scope of practice is the area or areas of a registrant’s profession in which they have the knowledge, skills and experience to practise lawfully, safely and effectively, in a way that meets the HPC’s standards and does not pose any danger to the public or to themselves.

A registrant’s scope of practice will change over time, and the practice of experienced registrants often becomes more focused and specialised than that of newly registered colleagues. This might be because of specialisation in a certain clinical area or with a particular client group, or because of movement into roles in management, education or research.

Registrants must ensure that they are practising safely and effectively within their given scope of practice and do not practise in the areas where they are not proficient to do so. If they want to expand their scope of practice, they should be certain that they are capable of working lawfully, safely and effectively. This means that they need to exercise personal judgement by undertaking any necessary training and experience.
Medicines and the Standards of Proficiency

There are several Standards of Proficiency which are relevant. In section 3a.1 a generic standard states that health professionals must:

‘understand the structure and function of the human body, relevant to their practice, together with knowledge of health, disease, disorder and dysfunction’.

As the standard is a generic standard, it applies to all the professions that the HPC regulates.

Where a member of a profession can train as a supplementary prescriber, there is an additional profession-specific standard in Section 2b.4 which states that the professional must:

‘know and be able to apply the key concepts which are relevant to safe and effective practice as a supplementary prescriber in order to have their name annotated on the Register’.

The Standards of Proficiency can be downloaded from: www.hpc-uk.org/publications/standards/
Appendix 4

Allied health professional pre- and post-registration education and training

Physiotherapy

Pre-registration education

The current Curriculum Framework for qualifying programmes in physiotherapy\(^{41}\) identifies ‘clinical sciences’ as one of the six areas of underpinning knowledge required for practice. The framework describes the illustrative content of this area as including frequently encountered disorders of the following systems and their management:

- neurological;
- cardio-respiratory;
- neuromusculoskeletal;
- renal;
- endocrine;
- reproductive; and
- mental health.

Pharmacology: in the application of professional knowledge and skills, physiotherapists are required to understand their role in multidimensional healthcare and also be able to understand the integral nature of biological, physical, behavioural and clinical sciences in physiotherapy practice. Newly qualified physiotherapists will have a basic level of education, training and competence in understanding the role of medicines in the care of patients commensurate with their experience and personal scope of practice.

Post-registration education and training

Physiotherapists may gain additional education, training and competence in pharmacology, medicines and their use in a variety of settings. For example:

- in-house training to join an on-call rota;
- in-house training to be able to use a Patient Group Direction (PGD);
- external short courses run by commercial companies or universities covering; medicines use relevant to an area of practice; and
- courses validated by professional bodies or universities offering training in specific techniques that require the use of medicines, e.g. corticosteroid and local anaesthetic injection therapy for musculoskeletal conditions or botulinum toxin injection for neurological conditions.

Physiotherapists fulfilling the prerequisites of validated training programmes are eligible to undertake training to qualify as supplementary prescribers.

**Podiatry**

**Pre-registration education**

In addition to the study of the basic life sciences, podiatric medicine and podiatric surgery, pre-registration training addresses relevant pharmacology (including local anaesthesia), thus enabling graduates to access, via the HPC register annotations, ‘sale/supply’ and ‘administration’ rights to a range of specified prescription-only medicines (POM) and pharmacy (P) medicines available to podiatrists. The curriculum also includes psychosocial aspects of healthcare, law and ethics as applied to practice. Several modules are shared with other AHPs, medical programmes and nursing programmes in many universities. In particular, undergraduate students must successfully complete modules in pharmacology, covering relevant aspects of law, principles of pharmacodynamics and pharmacokinetics, and the study of a wide range of medicines, their use, indications, contraindications and complications. Applied aspects of pharmacology and medicines are embedded in the clinical elements of the programme, which include skills in medical history, clinical examination and clinical diagnosis. A separate (or in most instances integrated) module on local anaesthesia is required to enable students to undertake this training and examination.

**Post-registration education and training**

A number of postgraduate programmes exist at both Master’s and Doctorate levels. The Master’s degree (MSc) in the Theory of Podiatric Surgery, jointly endorsed by the Society of Chiropodists and Podiatrists and the Royal College of Physicians and Surgeons of Glasgow, provides the academic underpinning that supports the development of practitioners seeking to undertake pupillage training in podiatric surgery. Since 2005, podiatrists fulfilling the prerequisites of validated training programmes have been eligible to undertake training as supplementary prescribers. Courses in corticosteroid injection therapy for specialist podiatrists incorporate relevant pharmacology training and are endorsed by the Society of Chiropodists and Podiatrists.

**Radiography**

**Pre-registration education**

The three-year degree programme is separate for diagnostic and therapeutic radiography. Approved courses follow requirements described in the *Learning and Development Framework for Clinical Imaging and Oncology*.  

The programme leading to qualification as a diagnostic radiographer includes:

- the legal basis of supply, administration and prescribing of medicines;

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the pharmacology of drugs commonly encountered within imaging settings, with a particular emphasis on contrast agents, associated drugs and radiopharmaceuticals; and the methods of administration of drugs.

The programme leading to qualification as a radiotherapy radiographer includes:
- pharmacology of drugs used in the relief of symptoms commonly encountered within the oncology setting, cytotoxic drugs, hormonal agents, imaging contrast agents and radiopharmaceuticals; and
- the methods of administration of drugs.

**Post-registration education and training**

Radiographers gain additional training in pharmacology and medicines in a variety of ways, including:
- in-house training to be able to use a PGD; and
- Master’s-level training in pharmacological management of treatment-related toxicity (radiotherapy).

Radiographers fulfilling the prerequisites of validated training programmes are eligible to undertake training to qualify as supplementary prescribers.

**Dietetics**

**Pre-registration education**

Dietetics is firmly based on an understanding of biological sciences. Applied sciences underpinning nutrition and dietetics are a major component and include biochemistry, physiology, genetics, immunology, microbiology, clinical medicine and pharmacology, alongside the more obvious nutrition, food, dietetics and public health components. This is complemented by social and behavioural sciences, including sociology and social policy, psychology, communication and educational methods, research and evaluation, public sector organisations and management.

Graduates will have an integrated knowledge and applied understanding of the modes of action of the main types of drugs; the functions, side effects and contraindications of drugs used in the treatment of diseases in which a dietitian is usually a key member of the clinical team; drug–nutrient interactions; and the use of nutrients as pharmacological agents.

**Post-registration education and training**

Dietitians access a wide variety of continuing professional development (CPD), including formal education at Master’s or Doctorate level.

**Orthoptics**

**Pre-registration education**

Programmes are designed to develop not only the professional expertise of the student for clinical practice but also effective communication, organisation and evaluation skills.
They include the relevant basic sciences, on top of which practical orthoptic skills can be acquired through clinical teaching. Programmes include theoretical and clinical orthoptics; optics; ocular anatomy; physiology and pathology; general anatomy and neuroanatomy; ophthalmology; electrodiagnosis; paediatrics; visual perception; child health; ethics and epidemiology; interpersonal skills; first aid; NHS structure and management; research methods and information technology; statutory bodies; and research dissertation.

During all three years of the degree programme, students are taught about the relevant medicines and drugs used in orthoptic and ophthalmological practice. This includes:

> basic pharmacology of mydriatics and miotics, including instillation actions and side effects in the treatment of amblyopia and accommodative esotropia;
> medicines and drugs which may cause disorders of accommodation;
> drugs used in the diagnosis and management of conditions which affect eye movements, e.g. myasthenia gravis and thyroid eye disease;
> drugs used in the management of nystagmus/oscillopsia; and
> drugs used for diagnosis and treatment of common pathology, e.g. glaucoma.

Post-registration education and training

There are a variety of options available, including:

> university programmes such as the postgraduate diploma/Master's in Vision and Strabismus; and
> in-house training provided by medical colleagues.

The British and Irish Orthoptic Society also provides post-registration education and training.

Speech and language therapy

Pre-registration education

Speech and language therapists cover the following broad subject areas:

> biological and medical sciences (including anatomy and physiology; neurology; ear, nose and throat; audiology; and mental health);
> linguistics (including phonetics and phonology, syntax and semantics, socio- and psycholinguistics, language acquisition and clinical applications of linguistics);
> research (including research methodology and evidence-based practice);
> social and behavioural sciences (including psychology, sociology, cognitive development and education); and
> speech and language pathology (including disorders of communication and fluency, cleft palate, autism, swallowing disorders, voice disorders, head and neck cancers, specific language impairment, stroke and aphasia).

Post-registration education and training

Throughout their careers, speech and language therapists are expected to take an evidence-based approach to their work. They need to keep up to date with current research and also engage actively with research activities and clinical audit. Speech and language therapists are expected to access a wide variety of CPD, including formal education at Honours, Master’s or Doctorate level.
Occupational therapy

Pre-registration education

Occupational therapists are experts in human occupation and purposeful activity. They use activity as an effective medium for remediating dysfunction, facilitating adaptation and recreating identity. The professional qualification in occupational therapy, at the point of registration for professional practice in the UK, is at Bachelor’s degree with Honours or its equivalent.

Subject areas studied include synthesis of theories of occupation and participation, with relevant knowledge from biological, medical, human psychological, social, technological and occupational sciences, including the pharmacological interventions that support recovery and maintain health and well-being.

Occupational therapists have an understanding of the types of medicines used in acute and long-term conditions commonly treated by occupational therapy, their side effects and properties that may affect occupational therapy intervention.

Post-registration education and training

Occupational therapy-specific advanced studies at post-registration level focus on occupational therapy approaches and interventions in specialist areas. These may include, for example:
> hand injuries;
> rheumatology;
> Parkinson’s disease;
> paediatrics;
> care of the elderly;
> palliative care;
> mental health; and
> learning disabilities.
Appendix 5

Non-medical prescribing and medicines supply mechanisms overview

<table>
<thead>
<tr>
<th>Mechanism summary</th>
<th>Additional notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A Patient Specific Direction</strong> is a doctor’s (normally written) instruction that enables a person to supply or administer a medicine to a named patient.</td>
<td>Useful in both primary care and secondary care. Wide-reaching (can encompass controlled drugs (CDs)). Relies on input of doctor.</td>
</tr>
<tr>
<td><strong>A Patient Group Direction</strong> is a written instruction for the supply and/or administration of a licensed medicine to a patient or group of patients, where the patient may not be individually identified. It must be agreed/signed by a doctor and senior pharmacist, and approved by the employer – typically a primary care trust or NHS Trust. It authorises named registered health professional(s) to supply/administer a licensed medicine.</td>
<td>Useful in many settings in primary care and secondary care. Can be slow to set up. Does not allow mixing of medicines. CDs: Schedules 4 and 5 may be included. Midazolam (now Schedule 3) can also be included. Diamorphine (Schedule 2) is also available to nurses in A&amp;E/critical care units.</td>
</tr>
<tr>
<td><strong>An Exemption</strong> (to medicines legislation) allows the sale, supply and administration of specific drugs in specific circumstances.</td>
<td>Useful in some settings. Used by podiatrists, paramedics, optometrists and midwives. Inflexible – only for named medicines.</td>
</tr>
<tr>
<td><strong>Supplementary Prescribing</strong> is a partnership with an independent prescriber (doctor) for a named patient, via an agreed patient-specific, clinical management plan. The supplementary prescriber can alter dosage, and remove or write prescriptions according to that plan.</td>
<td>Useful in some settings in primary care and secondary care. Original guidance stated: ‘Intended use mainly for long-term conditions and continuing care’. Dependent on link to and agreement of doctor.</td>
</tr>
<tr>
<td><strong>Independent Prescribing</strong> involves taking full responsibility for prescribing decisions and autonomously writing prescriptions.</td>
<td>Most flexible and responsive mechanism. Involves full responsibility for independent assessment, diagnosis and prescribing. Limitations on CDs.</td>
</tr>
</tbody>
</table>

**Note:** This is a summary of the main points for each mechanism. Full definitions can be found in DH and National Prescribing Centre guidance. An overview with definitions can be found in Department of Health (2006) *Medicines Matters*, London, Department of Health.

Appendix 6

Clinical examples

The following clinical examples illustrate a number of the issues identified in the report. Further clinical examples have been provided throughout the report to illustrate specific points.

Podiatry: surgery

A subset of podiatrists are highly trained in the surgical management of foot disorders. In the surgical management of a diabetic foot ulcer with osteomyelitis, the podiatrist will normally replace oral diabetic medications with intravenous insulin, alongside intravenous antibiotics. Medications for comorbidities such as hypertension require adjustment prior to, during and following the surgical procedure. A variety of medications may also be necessary to manage pain and anxiety.

Supplementary Prescribing cannot meet patient need in this clinical setting due to the breadth of unpredicted and acute circumstances that may arise. PGDs and Exemptions may not cover a specific medicine that is needed. Responsive dose alteration in response to changes in a patient’s condition (such as antithrombotic dose variation according to changes in international normalised ratio) may not always be possible with these mechanisms.

In recognition of the limitations of the existing prescribing and medicines supply arrangements, a surgical podiatrist may involve an independent prescriber (such as the patient’s GP), but this increases the risk of delays, may undermine confidence and also consumes GP time. Furthermore, misinterpretation of specific preparations can occur, such as the prescribing of heparin rather than a more appropriate low molecular weight antithrombotic such as enoxaparin. If non-emergency surgical complications arise (such as blood pressure fluctuations), the podiatrist’s inability to deliver appropriate medicines promptly under the existing arrangements can result in avoidable A&E attendance.

The quality and responsiveness of patient care could be improved and safety risks reduced by allowing suitably trained podiatrists to independently prescribe in this clinical pathway.
Physiotherapy: self-referral

The English physiotherapy self-referral pilots demonstrated equivalent clinical outcomes, greater treatment compliance and reduced work absence among patients who self-referred to physiotherapy compared with those who saw their GP first. There is now a commitment to increase the use of self-referral to improve access to AHP services where clinically appropriate. Exemptions and PGDs cannot accommodate the breadth of medication needs in this pathway. Supplementary Prescribing is incompatible with this care pathway because the physiotherapist is independently assessing, diagnosing and managing acute and long-term conditions in the absence of a doctor. Independent Prescribing is the mechanism that most suits the needs of patients in a self-referral pathway.

Dietetics: diabetic care

Dietitians help diabetic patients to improve their diabetic control through the use of both nutrition and medicines. In complex cases, erratic glucose levels can result in hospital admission. A dietitian may teach carbohydrate counting and concurrent titration of self-administered insulin doses to match carbohydrate intake. They also make recommendations to independent prescribers about additional medications, for example glucagon to help manage severe hypoglycaemic episodes, or long-acting insulin analogues to help manage nocturnal hypoglycaemia. Allowing dietitians to prescribe would improve patient care by increasing access to medicines; delays would be reduced and service productivity enhanced through a reduction in appointment duplication.

Podiatry: diabetic foot care

The High Risk Foot Protection Team (NHS Manchester, Manchester Community Health – North Locality) is a consultant podiatrist-led, acute and community-based rapid response high-risk foot care service. The service has reduced A&E attendance in its patient groups by 60%. Supplementary Prescribing has improved safety and clinical effectiveness of the service across both hospital and community settings. Clinical management plans (CMPs) are agreed remotely with GPs, allowing faster access to prescribing, improved medicines concordance and improved access for diverse and disadvantaged patient groups. It is one of few services to use Supplementary Prescribing in a community setting. Independent Prescribing would allow greater efficiency and value for money; it would also enable immediate prescribing for patients who currently face delays when a doctor is not available to agree the CMP.

Frequently asked questions

1. **Why extend access to medicines for allied health professionals?**

There are many potential benefits for patients, commissioners and providers. These are listed throughout the report. The project found that in extending prescribing and medicines supply for some allied health professionals (AHPs), there is potential to improve the quality of care – enhancing patient safety, clinical effectiveness and patient experience. This could be achieved by reducing delays in care; improving the use of medicines; improving patient experience through increasing access, convenience and choice; and improving productivity.

2. **Why not change the existing mechanisms?**

The existing prescribing and medicines supply mechanisms are fit for purpose. The problem is that some allied health professionals are unable to access the mechanisms that are most appropriate to their patients’ needs. The report contains examples in which the existing arrangements work well and examples in which patient need cannot currently be met because allied health professionals cannot access the appropriate mechanism. The project recommends expanding AHP access to the existing mechanisms.

3. **What happens next?**

This project has recommended that further work be undertaken towards extending prescribing and medicines supply mechanisms for some AHPs. The Department of Health Non-Medical Prescribing Board has accepted these recommendations and further work will now be undertaken. This will include public consultation. This process may take some time, as changes in professional access to prescribing and medicines supply mechanisms require legislative change. In previous non-medical prescribing developments, the entire process has taken around two years.

4. **Who will be involved in further work?**

The further work will include public consultation, and all key stakeholders will also be involved in the process.

5. **Can allied health professionals now prescribe independently?**

No.
6. **Why was the scoping project undertaken?**

This project primarily looked at whether there is a need for further work to be undertaken. Investigation into whether extension of prescribing and medicines supply for AHPs might benefit patients was key to this process. Some of the issues raised and contained in this report will inform public consultation.

7. **Is it safe to allow allied health professionals greater access to prescribing and medicines supply mechanisms?**

Patient safety is of paramount importance and is covered in detail in Section 6. Some allied health professionals already safely use Supplementary Prescribing or supply and/or administer medicines through Patient Group Directions, Patient Specific Directions and Exemptions. Not all allied health professionals would need greater access to medicines for their patients. This is why the recommendations are different for each profession. Even within a specific profession, only experienced or specialist practitioners would meet the prerequisites for prescribing training.

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

8. **Will prescribing costs increase?**

This is not anticipated – there is no evidence available to indicate that prescribing by other professionals, e.g. nurses and pharmacists, has increased prescribing costs. There are some early indications that prescribing by allied health professionals in some settings may actually reduce prescribing costs. Paragraph 9.6 provides further detail.