Health and Social Care

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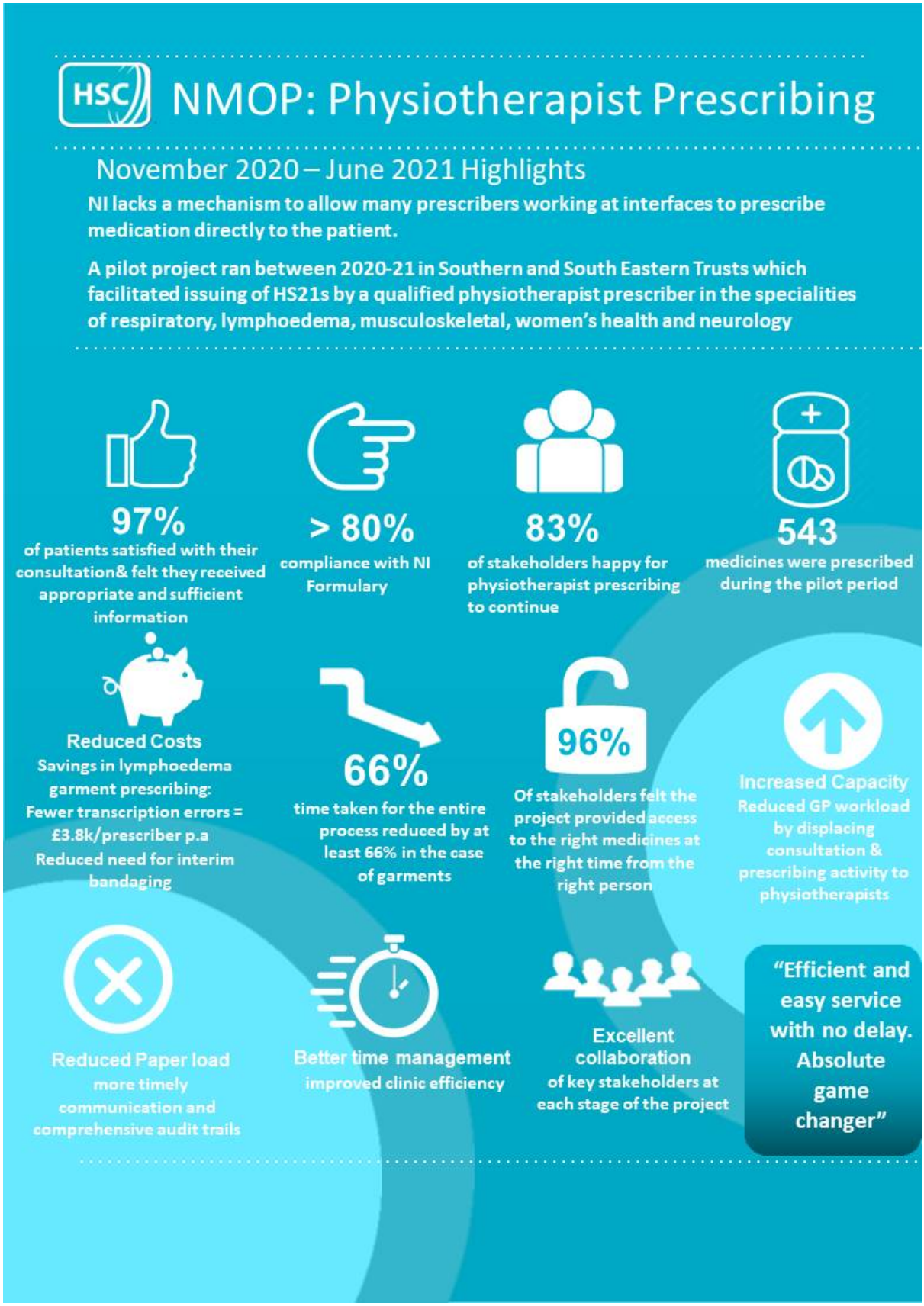
REVIEW AND RECOMMENDATIONS FOR NEW MODELS OF PRESCRIBING

A physiotherapist prescribing pilot

June 2022

New Models of Prescribing: Physiotherapist prescribing pilot



Task and Finish Group

A task and finish group was set up to oversee the implementation of the pilot project. Membership is detailed in table below:

Task and Finish Group Membership

Name	Title	Organisation
Eamon Farrell	AHP Consultant	PHA
Andrea Linton	NMOP Co-ordinator	HSCB[1]
James McAuley	NMOP Project Manager	HSCB[1]
Carmel Harney	Trust AHP Lead	SHSCT
Margaret Moorehead	Trust AHP Lead	SEHSCT
Lynne Whiteside	Trust Lymphoedema Clinical Lead	SHSCT
Elaine Mulligan	Trust Service Lead, Community Heart Failure and Respiratory Services	SHSCT
Anne-Marie Campbell	Service team Lead Community Respiratory (Interim)	SHSCT
Roisin Skeffington	Trust Team Manager Orthopaedic Integrated Clinical Assessment and Treatment Services (ICATS	SHSCT
Gail McKeown	Principal Physiotherapist	SEHSCT
James Blackburn-Smith (until Jan 2021) **Jilly Redpath (from Feb 2021)**	Medicines Governance Pharmacist Medicines Governance Pharmacist	SEHSCT SHSCT
Denise Hall	Consultant Physiotherapist	SHSCT
Carla Devlin	GP	GPC
Glenda Fleming	Deputy Director	MOIC

[1]On 31 March 2022 the HSCB was closed and its staff and functions migrated to the Strategic Planning and Performance Group (SPPG) of the Department of Health on the 1st April 2022

Introduction

This report summarises the evaluation of the New Models of Prescribing (NMOP): Physiotherapist prescribing pilot project. It includes the outcomes from the project and recommendations based on the evaluation results and learning from the development of new processes.

The full report and evaluation data are available from the MOIC report.

Executive summary

The number of healthcare practitioners in Northern Ireland who are eligible to prescribe continues to increase each year. In addition to the more traditional medical prescribers, appropriately qualified nurses and pharmacists have been able to prescribe independently since 1997. Additional professional groups such as podiatrists, optometrists and physiotherapists have more recently joined this list of authorised non-medical prescribers (NMPs). Traditionally, prescribers have worked in either primary or secondary care and mechanisms to facilitate prescribing are largely reflective of these two environments.

The Covid-19 pandemic has presented unprecedented challenges for the planning and delivery of HSC services, and a Strategic Framework for Rebuilding Health and Social Care Services has been developed which sets out the approach to restoring services as quickly as possible, taking into account examples of innovative approaches to service delivery, developed in response to the pandemic. Related initiatives such as the No More Silos – Urgent & Emergency Care Review, and the Primary Care Multi-disciplinary Teams Programmes further emphasise the increasing requirement for cross sector prescribing across the interface.

NI lacks a mechanism to allow many prescribers working at interfaces to prescribe medication directly to the patient. This report describes how processes to enable physiotherapist prescribing were implemented, tested and evaluated.

The physiotherapy profession covers a broad and diverse range of specialties. Prescribing may be required by a physiotherapist working in any of these areas. With the exception of First Contact Physiotherapists working in primary care, there is currently no mechanism in NI for prescribers to issue an HS21 prescription directly to the patient (this equated to approximately 75 qualified NMPs at the time of scoping in

September 2020). Recommendations made by these specialists have to be implemented by a GP, causing duplication of effort and delays in treatment. NMP physiotherapists have enhanced skills. Enabling prescribing would raise professional esteem in delivering a whole package of care for patients.

This New Models of Prescribing (NMOP) project facilitated issuing of HS21s by a qualified physiotherapist prescriber in the specialities of respiratory, lymphoedema, musculoskeletal, women's health and neurology.

Prescribing was permitted where there was:

- an urgent need for medication (within 72 hours of consultation),
- a requirement for titration/tapering of medicines with early review, or
- a need for specialised items outside the clinical expertise of a GP.

The project was supported by collaborative working involving HSCB, PHA, Trusts and GPs, in the form of a Task and Finish Group and ran from November 2020 to June 2021 in two Health and Social Care Trusts. Twenty-one physiotherapist prescribers participated.

Process maps were completed at baseline and at the end of the pilot. Baseline and end-point audits were completed to capture medicines prescribed, deprescribed and changed. Patient satisfaction was measured using questionnaires. Qualitative evaluation included recording of patient journeys, stakeholder satisfaction surveys and multi-disciplinary focus groups.

Positive outcomes from the project included:

- Excellent collaboration of key stakeholders at each stage of the project
- Displacement of prescribing activity from the GP, thereby increasing their capacity for other clinical duties
- The importance of the physiotherapist skill set during a pandemic specifically i.e. in the prevention of hospital attendances, and facilitating discharges

- Issuing of urgent prescriptions to manage COPD exacerbations and to support rehabilitation during COVID pandemic
- Particular benefit to some clinical specialities e.g. respiratory physiotherapy
- Implementation of robust governance systems and standardisation of processes which resulted in improved time management and avoidance of process duplication
- Better time management and improved clinic efficiency due to the reduction in number of steps needed and time taken to access prescriptions
- Improved data quality, reduced paper-load, more timely communication and comprehensive audit trails
- Patient access to specialist care which led to improved adherence with medicines and compression garments
- High level of patient satisfaction and confidence in the new pathway
- A reduced risk of inappropriate medicines/appliances being prescribed as transcription of a recommendation was no longer needed
- The development of an electronic treatment advice note to GPs which is now being utilised within other patient-facing services in both participating Trusts
- Reduced prescription costs
- Accrued savings in terms of nursing resource and bandage costs no longer required for the interim bandaging of lymphoedema patients
- Encouragement of professional autonomy, clinical responsibility, and increased professional standing leading to increased job satisfaction.

Challenges included:

- Time required to complete project paperwork
- Frustration experienced by musculoskeletal (MSK) physiotherapists due to their limited ability to prescribe controlled drug analgesics and muscle relaxants as a result of the restrictions within the Misuse of Drugs legislation
- Commencement of this pilot during the COVID-19 pandemic which impacted activity due to a decrease in face to face assessment and treatments

necessitated by implementation of infection, prevention and control measures and redeployment of staff to support the acute response during surge periods

- Occasional issues with GP practices receiving/accessing treatment advice notes
- Engagement with some community pharmacists and GPs despite the implementation of a communication strategy.

Enablers identified to support the key principles of NMOP (established during the scoping phase of the project):

Overarching principle: ***New Models of Prescribing should provide a robust governance framework to deliver equitable care for all patients in Northern Ireland***	
1	Access to HS21s for certain physiotherapist specialties should be streamlined into business as usual across all Trusts. Expansion should be explored in the areas of lymphoedema, respiratory, women's health and neurology and consideration should be given as to how this approach may add value to Hospital at Home and intermediate care across the region.
2	Benchmark any proposed future model with redesigned services in other regions
3	Monitoring arrangements should be implemented to provide assurance that prescribing is within professional prescribing parameters.
4	The learning should be applied at Trust level to inform Trust Governance frameworks / policies
Principle 1 ***Regional models of prescribing are required***	
5	Share outcomes and learning of the evaluation with key stakeholders including budget holders and policy makers
6	Establish regular prescribing update training for physiotherapist prescribers working at interfaces with primary care
7	Provide clarity to stakeholders regarding NMP prescribing budgets

8	Encourage interface physiotherapist prescribers to review, rationalise and implement a narrower range of medicines and appliances in line with evidenced based recommendations
9	Commission a regional service to ensure adequate resource
Principle 2 ***Simplified and clear prescribing and supply pathways***	
10	Implement electronic treatment advice notes to simplify the process
11	Standardise communication processes to GPs from Trust prescribing physiotherapists
12	SPPG should consider redesigning access to lymphoedema garments to make the pathway simpler and more efficient
13	Keep documentation to a minimum
Principle 3 ***Contemporaneous recording and communication of prescriptions***	
14	A technical solution to enable printing of HS21s by physiotherapists prescribing at the interface between primary and secondary care is fundamental to NMOP realising its full potential. This will require significant investment and collaborative ownership with colleagues working in digital healthcare.
15	Resource software and hardware needed to enable remote access to records
16	Raise awareness of interface physiotherapist prescribing with community pharmacists and GPs
Principle 4 ***Patient's GP practice will be the host of the complete prescribing record***	
17	Involve key stakeholders to facilitate GP prescribing record as the complete prescribing record i.e. GPC representatives, eHealth Project Manager, Trust Clinical Information System leads

18	Develop, test and implement robust processes to communicate with GP practices via Electronic Document Transfer

Principle 5 *Remote access to records*

19	Ensure outpatient physiotherapist prescribing is included within electronic prescribing programme
20	Share learning with ENCOMPASS programme
21	Enable remote access to decision support software for Trust physiotherapist prescribers

Principle 6 *Physiotherapist's role should be clinical*

22	Determine the appropriate skill mix and physiotherapist resource needed to support further expansion
23	Further work is required to simplify access to lymphoedema garments.
24	Consider how access to HS21s could be utilised more fully by MSK physiotherapists

Principle 7 *Medicines policy and legislation should enable new models of prescribing and supply*

25	Influence Advisory Committee on Misuse of Drugs and policy makers to amend the Misuse of Drugs legislation to enable MSK physiotherapist to prescribe additional controlled drugs
26	Consider impact of any Medicines Adherence policies on Trust physiotherapist prescribing
27	Share outcomes and learning of the evaluation with budget holders and policy makers
28	Align further expansion with DH policy in relation to prescribing and supply of medicines at interfaces with primary care

Specific recommendations identified for the future are:

Stakeholder engagement

1. Stakeholder ownership at regional and local level is key
2. Share outcomes and learning of the evaluation with key stakeholders including budget holders and policy makers
3. Misuse of drugs legislative change to support MSK physiotherapist prescribing of some controlled drugs will require further lobbying from professional leaders

Roll-out of new model

4. Access to HS21s for certain physiotherapist specialties should be streamlined into business as usual across all Trust. Expansion should be explored in the areas of lymphoedema, respiratory, women's health and neurology and consideration should be given as to how this approach may add value to Hospital at Home and intermediate care across the region
5. Benchmark any proposed future model with redesigned services in other regions
6. Learning from the NMOP pilot should be used at Trust level to inform organisation governance frameworks and policies

Supply mechanisms

7. SPPG should consider redesigning access to lymphoedema garments to make the pathway simpler and more efficient
8. Further work is required in order to be able to access cost data on lymphoedema garments. The current method to access this information requires many steps and further work may be required to determine a more sustainable mechanism

Workforce and resources

9. Firm commitments and clarity will be needed around NMP prescribing budgets
10. Determination of the appropriate skill mix and physiotherapist resource is needed to enable professional autonomy and to support further expansion
11. The ability to prescribe via virtual consultations requires further exploration and will require electronic prescribing to be enabled
12. A technical solution to enable printing of HS21s by physiotherapists prescribing at the interface between primary and secondary care is key to NMOP realising

its full potential. This will require significant investment and collaborative ownership with colleagues working in digital healthcare

Training and guidance

13. Regular prescribing update training for physiotherapist prescribers is fundamental to the success of any wider expansion
14. Physiotherapists should be encouraged to review, rationalise and implement a narrower range of medicines and appliances in line with evidence-based recommendations e.g. NI Formulary choices
15. Monitoring arrangements will need to be in place to provide an assurance that prescribing is within professional prescribing parameters.

As a result of the evaluation both Trusts have agreed to incorporate the prescribing mechanism into their normal service delivery. Further expansion to other Trusts or additional service areas is dependent on commissioning arrangements being agreed regionally and the commissioning of a technical solution to enable printing of HS21s by NMPs working at interfaces.

Based on the NMOP pilot project recurrent funding has now been made available from the Department of Health to establish an Integrated Prescribing Programme within the SPPG. This will include the scaling up of NMOP based on the recommendations outlined.

The experience of this NMOP project can serve as an example of the capacity and commitment required to deliver NMOP in other areas. Learning will be taken forward in to new clinical areas and across the region.

Overview of New Models of Prescribing project

Northern Ireland lacks mechanisms to allow some prescribers working at interfaces between primary and secondary care to prescribe treatments directly to their patients. This means that there may be duplication of work, with the original prescriber needing to work through the patient's General Practitioner (GP) to ensure that the required treatments are prescribed.

In order to address these issues, a transformation project, led by the Health & Social Care Board (HSCB) and involving extensive stakeholder engagement, was established to scope out the arrangements that need to be in place to enable prescribers working at the interface to work in a more effective and autonomous way. The stakeholder engagement established key principles to enable New Models of Prescribing (NMOP) (Figure 1).

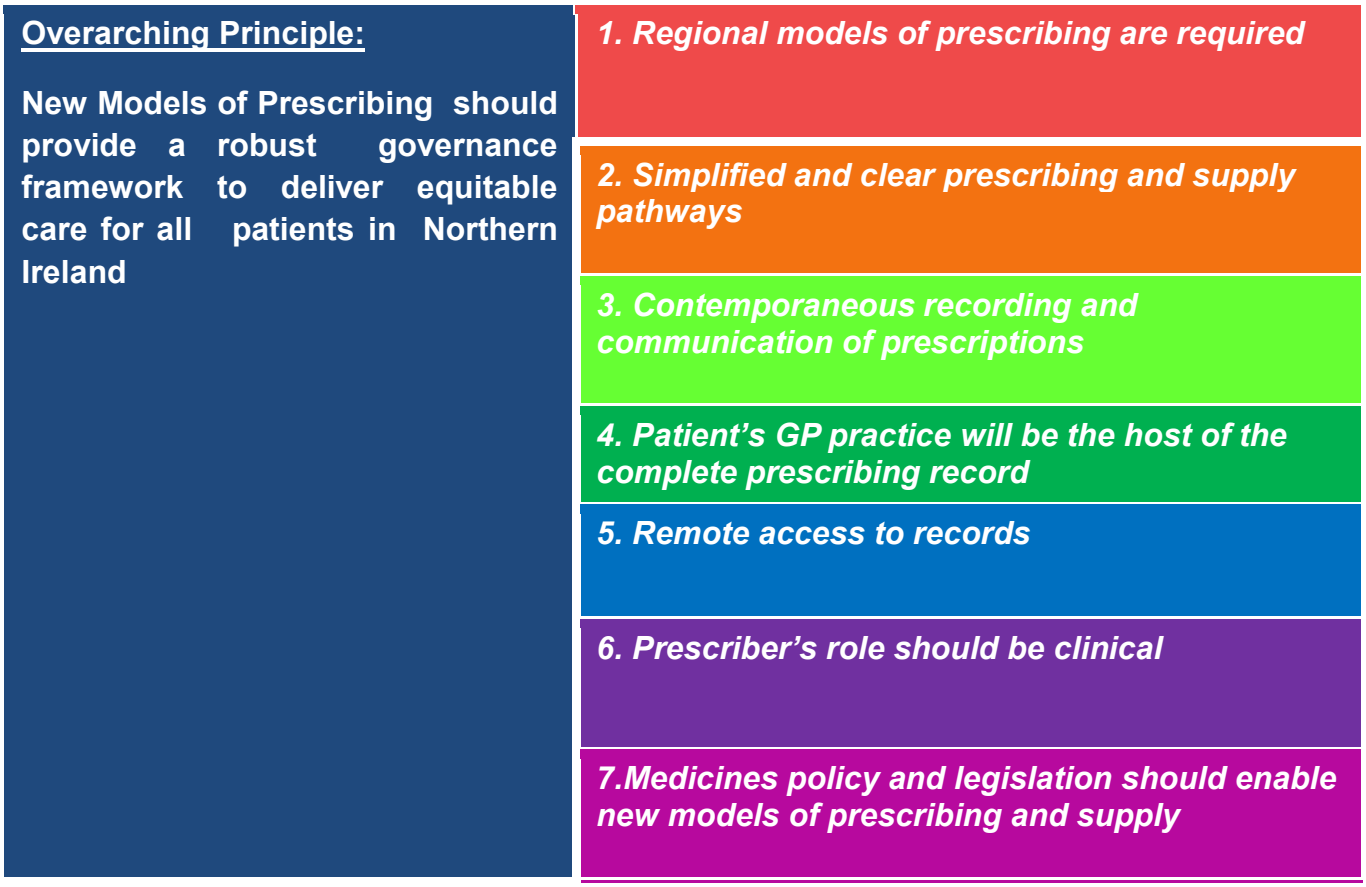


Figure 1 - Agreed NMOP Principles

A number of pilot projects were initiated to test the principles and explore the processes, governance and policy frameworks required for NMOP. The pilots included:

- Dietitian led direct ordering of oral nutritional supplements for care home residents
- Physiotherapist prescribing at the interface: community and outpatients
- Heart failure nurse specialist prescribing at the interface
- Mental Health Home Treatment Team medical prescribers

The Medicines Optimisation Innovation Centre (MOIC) is a regional centre in Northern Ireland dedicated to delivering medicines optimisation to the population. MOIC were tasked with assisting in the evaluation of the NMOP pilot studies.

One of the pilot projects focussed on physiotherapist prescribing at the interface. This report will describe the evaluation of and recommendations from that pilot.

Context

The physiotherapy profession covers a broad and diverse range of specialties. In Northern Ireland there are currently approximately 75 qualified prescribing physiotherapists (at the time of scoping in September 2020) employed across all Trusts. At least 18 of those specialise in respiratory, 15 in MSK and 5 in lymphoedema. With the exception of First Contact Physiotherapists working in GP Federation Multidisciplinary Teams, there is currently no mechanism for prescribers to issue a HS21 prescription directly to the patient. Recommendations made by these specialists have to be implemented by a GP, often causing duplication of effort and delays in treatment. Mechanisms to enable prescribing Physiotherapists to use their enhanced skills would empower the profession and improve patient care.

Aims and objectives of NMOP physiotherapy pilot evaluation

The overarching aim was to complete an evaluation of the NMOP physiotherapy pilot through joint working between MOIC, HSCB[1] and NMOP Physiotherapy Task and Finish Group.

The objectives were to evaluate:

Objective 1	The potential volume of prescribing activity that can be shifted to physiotherapist prescribers
Objective 2	The benefits in relation to access to prescribed items and reduced pressure on GPs
Objective 3	Perspectives on the delivery of tailored physiotherapy interventions to patients and maximising professional skills at the point of care delivery
Objective 4	Perspectives on the care pathways that can be delivered by a physiotherapist
Objective 5	Perspectives on patients accessing prescribed items
Objective 6	Perspectives on the impact on health care appointments and hospitalisations
Objective 7	Perspectives on patient / client concordance with taking prescribed items
Objective 8	Perspectives on communication processes to GPs regarding items prescribed.

[1]On 31 March 2022 the HSCB was closed and its staff and functions migrated to the Strategic Planning and Performance Group (SPPG) of the Department of Health on the 1st April 2022

Evaluation methodology

An analysis plan linking project objectives to the collected data was co-produced by MOIC, HSCB and clinicians participating in the NMOP pilot. Division of tasks under the plan was agreed between HCSB and MOIC (Appendix 2).

In line with the agreed analysis plan, the following outcome measurement and analysis was undertaken:

- **Stakeholder feedback sessions**: An agenda for a virtual feedback session was co-produced by HSCB and MOIC. Mentimeter software was used to capture quantitative agreement ratings and qualitative commentary from contributors. Qualitative feedback from participants was mapped to the project objectives using a theming approach (a theme or discussion point was summarised and presented, supported by quote extracts form contributors). Average agreement ratings from the participants on how the pilot met the project objectives, were summarised.
- **Stakeholder survey**: A survey co-designed by HSCB and MOIC was launched via Citizen Space. Descriptive statistics were used to summarise responses. Qualitative feedback from participants was themed and tabulated.
- **NMOP audit activity**: Clinicians were invited to submit prescribing activity from 1 week of their practice around the start (16/11/2020) and end (30/06/2021) of the pilot. In addition, clinicians were invited to submit de-prescribing activity from 1 week during a 4 week period from 1st March 2021. Audit activity was collated using Excel. Data was quality checked and re-categorised as necessary. Descriptive statistics were used to summarise activity at the start and end of the pilot and results were tabulated.
- **Process maps**: Clinicians participating in the NMOP pilot summarised their clinical workflow at the start and end of the pilot. The main steps from the process at the start and at the end of the pilot were extracted from the text and collated in flowchart figure. Key findings were summarised.
- **Patient journeys**: Clinicians participating in the NMOP pilot summarised patient journeys which emerged during the pilot. The full summaries and key findings were presented in text.

- **Patient Satisfaction Survey**: Patients receiving care as part of the NMOP pilot were invited to complete and submit a paper Patient Satisfaction Survey in person or via post. Descriptive statistics were used to summarise results. Direct quotes were extracted and presented.
- **Prescribing data**: Monthly prescribing data (number of prescribers, number of scripts, number of items, cost of items, average cost of item and average cost of item per prescriber) from the start to the end of the pilot was summarised using descriptive statistics.

Discussion points emerging from the analysis were formulated.

Results

Detailed results of the evaluation undertaken by MOIC and NMOP project team can be found at the following links; evaluation report and appendices.

Discussion

The physiotherapist prescribing pilot delivered an innovative and flexible programme to ensure that the patient remained at the centre of the physiotherapists' interventions. The multidisciplinary approach involving Trust AHP Leads, senior physiotherapists, and IT colleagues, GPs, community pharmacists, HSCB and BSO colleagues enabled the programme to be tailored to individual patient requirements and delivered integrated care.

The pilot demonstrated that excellent collaboration facilitated quality assurance at each stage of the project development. Regular Task and Finish Group meetings ensured that identification of issues were incorporated within service design and delivery.

Results, both qualitative and quantitative, were very positive. A number of favourable outcomes were described including benefits to the patient, health and social care system, and specific disciplines involved in the revised model of care. These are described as follows:

Benefits to patients:

A wide range of patient-perceived benefits were reported via the various data collection methods. Stakeholder feedback and process mapping highlighted that allowing physiotherapists to prescribe on HS21s **reduced the delay in accessing urgent medicines**. Audit activity showed that by the end of the pilot 4 out of every 5 medicines or garments prescribed by participating physiotherapists were issued using an HS21, compared with all items at start of the pilot being prescribed by a GP following a recommendation from the physiotherapist prescriber. As a result many patients were able to have their **medication dispensed on the same day as their physiotherapy assessment.** The process mapping exercise verified this indicating that the revised model reduced the number of steps by an average of 2 steps across all the disciplines. While it is not possible to quantify, this is likely to result in savings accrued due to reduced professional input.

Furthermore, the **time taken for the entire process** (initial physiotherapist assessment to receipt of item via CP) **reduced by at least 66%** in the case of garments and at 43% in the case of medicines, as assessed by the process maps. The most significant change in process was within the lymphoedema service, where the time taken to receive a garment following physiotherapist assessment was reduced from 3-6 weeks to between 7 and 10 days, if supply was made by DAC. This **shortened the length of time interim bandaging** needed to be applied by community nurses, reducing this burden on patients and increasing nursing capacity for other clinical duties. A session of complete decongestive therapy usually takes between 60-90 minutes which will entail manual lymphatic drainage. This is costed at approximately £123 - £185 according to the British Lymphology Society (https://www.thebls.com/public/uploads/documents/document-90631551700163.pdf). Based on one prescriber looking after 10 patients per month and reducing the need for interim bandaging sessions by one session per patient, it is estimated that community nursing costs could be reduced by £15k-£22k per lymphoedema physiotherapist prescriber per year.

There were numerous examples of the patient receiving **the right medicine from the right person at the right time.** This access to specialist care led to **improved adherence** with Acute Care At Home (ACAH) medicines and lymphoedema garments and enabled timely prescription of medicines for a range of acute respiratory conditions. NMOP improved prescription access for all patients including patients seen via remote consultation.

Feedback from stakeholders and patients reported **increased satisfaction** and confidence in the new pathway. Stakeholder engagement during the scoping phase of NMOP and previous audits highlighted that, due to an extensive range of lymphoedema garments being available and lack of GP knowledge of this therapeutic area, incorrect products were often selected from drug dictionaries on GP clinical systems and prescribed. This delayed the appropriate management of patients and had resource implications. At the end of the pilot stakeholders reported a **reduced risk** of inappropriate medicines/appliances being prescribed as a consequence of removing the transcription step that previously required GPs to implement physiotherapist prescribers' recommendations.

Patient journeys provided examples of **increased patient convenience** with the new model. The NMOP intervention may possibly have avoided re-attendance during the Easter holiday period for one patient. Almost 60% reported that the new model saved the patient time. In some of these cases, time was saved as a GP appointment was no longer required. The NMOP also enabled patients, who consulted the specialist remotely, to arrange for collection of prescriptions from a Trust base if that was more convenient. The patient survey provided an assurance that patients were provided with medication and garment information, as almost all patients reported that they received sufficient information on the item prescribed, including likely duration of treatment, potential side-effects and the process for obtaining a repeat prescription if needed. Patients reported **high levels of satisfaction** with the service.

The results from the evaluation of prescriber activity highlight the importance of **holistic patient management.** For example, in the prescription of inhalers, there was careful consideration of both the inhaler medication and device, dependent on patient factors. Inhaler devices were by far the most commonly prescribed item (37%). NMOP

enabled more holistic management in the follow-up of post-COVID pneumonia patients by providing a time-sensitive opportunity to reinforce smoking cessation activity via the direct prescription of NRT products and encouragement of lifestyle changes.

In all therapeutic areas the prescribers exceeded 70% compliance with NI Formulary choices (range 81% to 100% compliance) indicating that prescribing was evidence-based.

Benefits to the healthcare system:

Stakeholders reported that the model owed its success, in part, due to clear, efficient and timely communication between prescribers and other stakeholders. **Robust governance systems and standardisation of processes** resulted in improved time management and avoidance of process duplication.

The development, rigorous testing and deployment of digital communication systems via Electronic Document Transfer to GP practices resulted in **improved data quality, reduced paper-load, more timely communication and comprehensive audit trails.**

NMOP also enabled more direct and timely communication between lymphoedema physiotherapists and DAC suppliers, when the DAC supply route was being utilised, **reducing the risk of transcription errors** as seen when GPs were asked to issue prescriptions for lymphoedema garments. An audit carried out by WHSCT in 2015 reported that 16.6 % of all orders for lymphoedema garments in primary care were incorrect when received by the patient (and not as requested by the therapist). Almost one-fifth of the (eventually correct) garment orders requested via HS21 required additional phone calls from either GP practices /pharmacies to the lymphoedema service to ascertain the correct garment on the GP clinical system. This had a secondary impact on the therapist's time as well as the GP and Pharmacy services. The cost to the Trust for the mistakes due to basic transcribing and prescribing errors was an average £27 per prescription. Direct involvement of the physiotherapist in writing the prescription will therefore have benefits in terms of **reduced prescription costs.**

The results from the evaluation of this NMOP highlight the importance of the physiotherapist skill set during a pandemic specifically with stakeholder feedback reporting that activity had the potential to **prevent hospital attendances, and facilitate discharges.** During the pandemic GP capacity was reduced and patients contacted the physiotherapy teams directly on occasions to obtain urgent prescriptions.

A shorter process had the added benefit of reduced costs, for example, the accrual of **savings in terms of nursing resource and bandage costs** which were no longer required for interim bandaging of lymphoedema patients awaiting access to compression garments. One of the recorded patient journeys concluded that NMOP had a positive impact on wider MDT as access to the compression garment sooner means less need for community nursing visits to undertake compression bandaging.

Benefits to Physiotherapists:

Physiotherapists participating in the stakeholder feedback session and responding to the survey recorded that NMOP **encourages professional autonomy**, clinical responsibility, and increased professional standing leading to increased job satisfaction. Furthermore, NMOP empowers clinicians to de-prescribe medications that a patient may no longer require.

The NMOP was **particularly beneficial to some clinical specialities** (respiratory) and less so in others (MSK). The reasons for this are multi-factorial e.g. the nature of the medications prescribed (i.e. controlled drugs in MSK patients) and the acuity of the condition being managed e.g. COPD exacerbation versus joint inflammation.

The evaluation found that there was a reduction in the proportion of physiotherapists needing to contact GPs to generate a prescription leading to **better time management** and cost savings. Reduced queries from patients and healthcare professionals led to **improved clinic efficiency** and increased capacity of the team to see more patients.

Enabling patients to access compression garments faster meant more **efficient management of physiotherapist caseload.**

Audit data indicated an increase in other activity linked to changes to medication or garment e.g. completion of Home oxygen order forms. This result highlights that physiotherapists were utilising their existing prescribing skills alongside their new skills

enabled by the NMOP. It also underlined how both the existing and new skills were essential for the holistic management of patients.

Benefits to GPs:

Evaluation of audit data found that there was a reduction in the proportion of physiotherapists needing to contact GPs to generate a prescription. As well as **reducing GP workload** this would lead to subsequent cost savings.

Displaced prescribing activity and consultation activity from GPs to physiotherapists was also reported by stakeholders. NMOP enabled **improved communication** via the development of electronic transfer of treatment advice notes to GP practices. Furthermore, just under half of those patients surveyed no longer required a GP appointment.

Stakeholder feedback suggested that as a result of NMOP **GPs were more aware of the role of NMPs.** Physiotherapist prescribers **supported GPs during COVID** pandemic by being able to issue urgent prescriptions to manage COPD exacerbations and to support rehabilitation.

Challenges

The pilot also provided an opportunity to identify the constraints of the new prescribing process and aspects that would require further consideration before any further roll-out of this new model.

Physiotherapist prescribers participating in the pilot reported that completion of GP advice notes to advise that an HS21 had been issued, could **be time consuming** and there was a requirement to complete **additional project paperwork.**

MSK physiotherapists were particularly frustrated by their **limited ability to prescribe controlled drug** analgesics and muscle relaxants due to the current restrictions of the Misuse of Drugs legislation. Audit data confirmed that there was **less engagement of physiotherapists working in the ICATS/MSK** fields due to limited ability to prescribe coupled with redeployment of this group of physiotherapists during the pandemic. Furthermore, the nature of many MSK ailments and the waiting times from referral to assessment meant that many patients had passed the acute phase of their illness by the time they were seen and medicines had already been issued by the patient's GP.

There were specific challenges in implementing the NMOP, that could not have been anticipated but that emerged through stakeholder feedback. Commencing this pilot during the **COVID-19 pandemic** caused difficulties as there were limitations to prescribing at virtual consultations. Implementation was also affected by staff sick leave and redeployment due to COVID-19.

Some GPs surveyed reported occasional **issues with receiving/accessing treatment advice notes.** It was evident that some were not aware of the transmission of treatment advice notes to GP document management systems via EDT.
Despite implementation of a communication strategy it was **challenging to engage with all community pharmacists and GPs** across the Trust geographies, as they too were facing immense workload pressures due to COVID. This resulted in a lack of awareness of NMOP among some GPs.

Future considerations and recommendations

The success of this and other NMOP pilots has led to new HSC posts being secured regionally with recurrent funding to the Strategic Planning and Performance Group. The experience of this NMOP project can serve as an example of the capacity and commitment required to deliver a NMOP in other areas. Collective leadership, stakeholder engagement from the outset, capacity to facilitate and attend regular meetings, robust communication strategy and clearly-defined outcomes were all paramount to successful implementation.

Specific considerations / recommendations for the future are as follows:

1. Access to HS21s for certain physiotherapist specialties should be streamlined into business as usual across all Trust. Expansion should be explored in the areas of lymphoedema, respiratory, women's health and neurology and consideration should be given as to how this approach may add value to Hospital at Home and intermediate care across the region.
2. Share outcomes and learning of the evaluation with key stakeholders including budget holders and policy makers**.**
3. Stakeholder ownership at regional and local level is key.
4. Learning from the NMOP pilot can be used at Trust level to inform organisation governance frameworks and policies.

5. Determination of the appropriate skill mix and physiotherapist resource is needed to enable professional autonomy and to support further expansion.
6. Benchmarking of any proposed future model with redesign of services in other regions.
7. Regular prescribing update training for physiotherapist prescribers is fundamental to the success of any wider expansion.
8. A technical solution to enable printing of HS21s by physiotherapists prescribing at the interface between primary and secondary care is key to NMOP realising its full potential. This will require significant investment and collaborative ownership with colleagues working in digital healthcare.
9. SPPG should consider redesigning access to lymphoedema garments to make the pathway simpler and more efficient.
10. Physiotherapists should be encouraged to review, rationalise and implement a narrower range of medicines and appliances in line with evidence-based recommendations e.g. NI Formulary choices.
11. Firm commitments and clarity will be needed around NMP prescribing budgets.
12. Misuse of drugs legislative change to support MSK physiotherapist prescribing of some controlled drugs will require further lobbying from professional leaders.
13. Monitoring arrangements will need to be in place to provide an assurance that prescribing is within professional prescribing parameters.
14. The ability to prescribe via virtual consultations requires further exploration and will require electronic prescribing to be enabled.
15. The NMOP evaluation found that further work is required in order to be able to access cost data on lymphoedema garments. The current method to access this information requires many steps and further work may be required to determine a more sustainable mechanism.