Appendices

An Evaluation of New Models of Prescribing (NMOP):

A Physiotherapist Prescribing Pilot

November 2021

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Appendix 1: Terms of Reference

New Models of Prescribing –
Physiotherapist prescribing at the interface: community and outpatients
Task and Finish Group
Terms of Reference

1.0. Background to New Models of Prescribing

Northern Ireland lacks a mechanism to allow many prescribers working at interfaces between primary and secondary care to prescribe medication directly to the patient that can then be dispensed in the community. This can result in duplication of work, with the original prescriber needing to work through the patient's GP to ensure that the required medicines are prescribed.

A transformation project 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 project considered new and transformative processes to allow prescribers to prescribe directly to patients, rather than going through a third party, and proposed mechanisms to enable new models of prescribing (NMOP). A business case has been developed and sets out a proposal to invest in the development of an Electronic Care Record (ECR) solution to enable the production of HS21 prescriptions at interfaces between Primary and Secondary care. Northern Ireland currently has no technology solution to enable the printing of HS21 prescriptions at these interfaces. The proposed ECR solution will enable qualified medical and non-medical prescribers working in for example, Outpatient Clinics, and Intermediate Care Units, to issue prescriptions directly to patients rather than relying on the patient's GP to implement the recommendations.

A number of pilot projects will be initiated to test process, governance and policy frameworks required for NMOP in a small number of sites. One of the pilot projects will focus on physiotherapist prescribing at the interface.

2.0. Background to Physiotherapy Prescribing

The physiotherapy profession covers a very broad and diverse range of specialties. Prescribing may be required by a physiotherapist working in any of these specialist areas. Individual physiotherapists who develop advanced expertise tend to do so in one specialist area of clinical practice only. Therefore whilst the prescribing activity of the profession as a whole may appear broad and diverse, the individual activities of any one prescribing physiotherapist will be focused only within their chosen specialist area of practice.

In Northern Ireland there are currently approximately 75 qualified NMP physiotherapists employed across all Trusts. At least 18 of those specialise in respiratory,15 in musculoskeletal and 4 in lymphoedema. With the exception of First Contact Physiotherapists working in GP Federation Multidisciplinary Teams, there is currently no mechanism for prescribers to issue an HS21 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. NMP Physiotherapists have enhanced skills and enabling prescribing would raise professional esteem in delivering a whole package of care for selected patients. NMP Physiotherapists are motivated health care professionals and are ideally placed to be innovative in their approach to timely service delivery.

During the Covid-19 pandemic, respiratory physiotherapists would have welcomed the ability to issue supporting medication when managing patients post-discharge and as part of their rehabilitation. MSK physiotherapists are well-placed to provide multi-modal approaches to the management of low back pain. It is estimated that MSK complaints account for approximately 30% of GP appointments. Lymphoedema physiotherapists are specialists in selecting the most appropriate compression garment to manage patients' conditions, but do not currently have the mechanism to prescribe directly to the patient and rely on GPs to implement their recommendations, this process can delay the supply of garments and the delay can be clinically significantly in some cases.

3.0. Aims and Objectives of the Physiotherapist Prescribing Pilot Task and Finish Group

The aims of the pilot will be to:

- Facilitate the issuing of HS21s by a qualified physiotherapist NMP in the areas of respiratory (e.g. COPD, asthma, cystic fibrosis), musculoskeletal (e.g. low back pain) and lymphoedema specialities.
- Explore existing barriers in policy and legislation to NMP in the community and outpatient setting and work closely with the Policy, Legislation and Governance Subgroup to overcome these barriers
- Develop robust governance arrangements to ensure safe and effective prescribing practice
- Work closely with Trust Pharmacy leads to make changes to Trust Policies and Procedures as required
- Develop prescribing processes that address existing logistical challenges re: communication with primary care, timely updating of clinical records, interface with community pharmacy.

- To establish an effective funding mechanism, which is not directly linked to a GP Cipher code, to permit physiotherapists working across multiple practices to prescribe at the interface.

The objectives of the pilot project are to:

- Establish potential volume of prescribing activity that can be shifted to physiotherapist prescribers
- Identify benefits in relation to access to medication and reducing pressure on GPs
- Support and enhance the delivery of tailored physiotherapy interventions to patients, maximising professional skills at the point of care delivery
- Support the delivery of care pathways that can be delivered by a physiotherapist
- Reduce delays in patients accessing medication - greater opportunity to access the right medicines, at the right time, from the right person.
- Support a reduction in the amount of unnecessary health care appointments and hospitalisations and promote faster recovery and self-caring.
- Support improvements in patient / client concordance with taking prescribed medicines.
- Establish communication processes to GPs regarding items prescribed.

3.1. Chair

The physiotherapist prescribing pilot task and finish group will be chaired by Eamon Farrell, AHP Consultant, Public Health Agency.

3.2. Frequency of Meetings

The physiotherapist prescribing pilot task and finish group will meet monthly.

3.3. Pilot Locations

The pilot will run across two Trust areas. The Southern Trust and South Eastern Trust areas have been selected based on the number of qualified NMP prescribers and their willingness to participate in the pilot project.

4.0. Physiotherapist Prescribing Pilot Task Membership

The membership is as follows:

Name	Title	Organisation
Eamon Farrell	AHP Consultant	PHA
Andrea Linton	NMOP Co-ordinator	HSCB
James McAuley	NMOP Project Manager	HSCB

Carmel Harney	Trust AHP Lead	SHSCT
Margaret Moorehead	Trust AHP Lead	SEHSCT
Lynne Whiteside	Physio rep	SHSCT
Elaine Mulligan	Physio rep	SHSCT
Roisin Skeffington	Physio rep	SHSCT
Gail McKeown	Principal Physiotherapist	SEHSCT
James Blackburn-Smith (until Jan 2021) Jilly Redpath (from Feb 2021)	Trust Pharmacy Rep Trust Pharmacy Rep	SEHSCT SHSCT
Denise Hall	Consultant Physiotherapist	SHSCT
Dr Carla Devlin	GP	GPC
Glenda Fleming	Deputy Director	MOIC

Appendix 2: Analysis plan

Overview of project aims and objectives:

The project considered new and transformative processes to allow prescribers to prescribe directly to patients, rather than going through a third party, and proposed mechanisms to enable new models of prescribing (NMOP).

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In addition: to evaluate
- whether or not the aims and objectives of the project have been met using various data collection methods e.g. surveys, audits, patient stories, correspondence and a stakeholder workshop.

Analysis mapped to aims and objectives:

Data/info sources to consider:

- clinician reports (excel),
- Mentimeter reports (excel)
- stakeholder surveys (citizen space),
- patient surveys (paper),
- process maps (word document),
- minutes from task and finish groups and other workshop meetings at the end of project (word documents) for qualitative reports
- Patient stories
- Prescribing data from HSCB

Objective	**Suggested analysis**	**Data processing required**	**Decision on who is responsible and agree an approx. timeline**
• Robust governance arrangements in place to ensure safe and effective prescribing	• Stakeholder survey Qualitative comments related to governance arrangements • Workshop reports Qualitative Themes reported by stakeholders to governance arrangements	• Descriptive bullet points of main themes • Mentimeter ratings	James McAuley – HSCB *Stakeholder Survey/ Menti - end of July*
• To understand the prescriber and patient cohort	• Sample characteristics table suggested below.	See table 1 below	MOIC – end of July
• Establish potential volume of prescribing activity that can be shifted to physiotherapist prescribers	There are a few data sources that could be used if relevant, to address this objective: • This would be addressed by table below - as would summarise the volume of work covered during the pilot? • In addition analysis of baseline and final audit results which would measure activity / change in activity? The variable of interest could be number of patients? Would	• As above • This analysis would require creation of a new excel counting and logging the number of patients pre and post for each prescriber	James McAuley – HSCB w/c 19th July

	need matching data for each prescriber. • Process map info : compare volume of work pre project process map with final process map	• n/a as figures already reported	*Look at steps involved – August*
• Identify benefits in relation to access to medication and reducing pressure on GPs	• Quantitative Activity as captured by the audit excels (final version) Results table 2 below (Medication usage and GP contacts) • Process map Change in number of steps on pathway to prescription in patient access to medication (mean over all prescribers) Change in number of contacts with the GP in patient access to medication (mean over all prescribers) • Stakeholder survey	• Creation of new excel sheet bringing separate prescriber figures together and calculation of means • This analysis would require some further processing of the process map documents including count of number of steps and number of contacts – for each prescriber • None required - can use direct question responses	**MOIC – End of July** James McAuley – HSCB **– August**

	N (%) reporting benefits related to access to medication and reducing pressure on GPs • Workshop reports Qualitative Themes reported by stakeholders on access to medication and reducing pressure on GPs	• Descriptive bullet points of main themes • Mentimeter ratings	James McAuley – HSCB **– end of July** **MOIC – Menti ratings – end of July** James McAuley – HSCB **– minutes etc. – Mid July**
• Support and enhance the delivery of tailored physiotherapy interventions to patients, maximising professional skills at the point of care delivery	• Process map Change in number of steps on pathway to prescription in patient access to medication • Stakeholder survey N (%) reporting benefits related to delivery of interventions N (%) reporting benefits to professional skills Qualitative themes on positives of project and changes for full implementation	• This analysis would require some further processing of the process map documents including count of number of steps – for each prescriber • None required - can use direct question responses • Descriptive bullet points of main themes • Mentimeter ratings • Descriptive bullet points of main themes	James McAuley – HSCB August James McAuley – HSCB end of July James McAuley – HSCB

	• Workshop reports Qualitative Themes reported by stakeholders on delivery of interventions. maximising professional skills		August
• Support the delivery of care pathways that can be delivered by a physiotherapist	Qualitative themes reported on delivery of care pathways • Workshop reports Qualitative themes reported by stakeholders on delivery of care pathways	• Descriptive bullet points of main themes • Descriptive bullet points of main themes • Mentimeter ratings	James McAuley – HSCB – end of July/August **MOIC** – end of July
• Reduce delays in patients accessing medication - greater opportunity to access the right medicines, at the	• Qualitative reports from patient stories Patient satisfaction questionnaire – mean (SD) N (%) patients reporting benefits	• Verbatim quotes or Descriptive bullet points of main themes • Was the patient survey paper or electronic? Compilation and summary of these responses would be required • Mentimeter ratings	James McAuley – HSCB – end of July *(get from Andrea)* James McAuley – HSCB

right time, from the right person.			Pt Satisfaction Survey – end of July. **MOIC** – end of July
• Support a reduction in the amount of unnecessary health care appointments and hospitalisations and promote faster recovery and self-caring.	• Process map Change in number of contacts on pathway to prescription • Patient stories Any themes emerging relating to faster recovery and self- care • Patient satisfaction questionnaire mean (SD) N (%) patients reporting benefits relating to hospitalisation, recovery and self-caring	• This analysis would require some further processing of the process map documents including count of number of contacts – for each prescriber • Descriptive bullet points of main themes • Was the patient survey paper or electronic? Compilation and summary of these responses would be required • Mentimeter ratings	James McAuley – HSCB August James McAuley – HSCB end of July (get from Andrea) James McAuley – HSCB Pt Satisfaction Survey – end of July. **MOIC** – end of July
• Support improvements in patient / client concordance with taking prescribed medicines.	• Patient satisfaction questionnaire Mean (SD) N (%) reporting “agree” to Q 1-9 • Stakeholders survey	• Was the patient survey paper or electronic? Compilation and summary of these responses would be required • Descriptive bullet points of main themes	James McAuley – HSCB Pt Satisfaction Survey – end of July.

	Qualitative themes reported on improvements in patient / client concordance • Workshop reports Themes reported by stakeholders on improvements in patient / client concordance	• Descriptive bullet points of main themes • Mentimeter ratings	James McAuley – HSCB end of July (open ended questions) *Check through for additional information in workshop report* MOIC – end of July
• Establish communication processes to GPs regarding items prescribed.	• Workshop reports Themes reported regarding communication processes to GPs • Stakeholders survey (Question 3 of survey)	• Descriptive bullet points of main themes • Mentimeter ratings	MOIC – end of July James McAuley – HSCB – end of July

Appendix 3: Feedback from stakeholder sessions

Appendix 3.1: Summary of key themes mapped to each objective and supporting extract

Objectives	Themes	Supporting Extract
Robust governance arrangements in place to ensure safe and effective prescribing	Standardisation of processes	NMOP highlighted the issues that needed to resolved, increased awareness and helped to standardise processes. A consistent approach will be required for roll-out
		The process has been done well, started small, worked through issues, governance etc
	Duplication/Domicillary Care	Need to avoid duplication, allergies and alert needs to be checked, making sure prescriber aware of impact on patient where carers are involved
	IT systems	Effective communication was supported by the generation of mismatch and comparison reports between Trust and GP systems – provided an opportunity to quickly follow-up and implement fixes. Close linking with between EDT, PARIS and Data Quality personnel. Has provided an opportunity to scope out process that needs to be followed if replicating for other services.
		can see a risk attached to the sustainability based on the comparison and mismatch reports. PARIS doesn't have interface with HCN, element of risk, if patient has changed GP and not up to date.
	Legislation/Policy	Policy covers needs to be in place for continuation of pilot

	Communication/ Networking	Zoom meetings reduced ability for local networking to tease out some local governance issues (impact of COVID)
		Had little awareness of project prior to being asked to step in. Has highlighted level of disconnect between those directly involved in project and wider teams in Trusts e.g. pharmacy, medics, IT, ACAH etc- this will reduce the risk of incomplete med reconciliation, duplication and errors.
	Resource	everything is small scale at present - AHP prescribing governance support will be required in Trust if this grows

Objectives	Themes	Supporting Extract
Identify benefits in relation to access to medication and reducing pressure on GPs	**Reduction of errors**	Lymphoedema- reducing errors in the garments delivered when using the HS21.
	Improved/faster access to meds	ACAH, pts have been able to get the medications in their homes with help from the families. Patients can get this much quicker than coming from hospital pharmacy and delivering out.
		Lymphoedema- The patients have been able to get the correct garments and often delivered to their home. this can be a difference of 2.5 months via GP to 5-7 days if directly prescribed on an HS21.
		Acutely unwell patients in respiratory clinic can get urgent medications within 2 hours rather than waiting a few days for urgent care. this can make a difference to whether the patient is admitted to hospital
	Patient Satisfaction	Improved satisfaction as patients receive prescribed items sooner
		It removes the barriers for the patient between secondary care and primary care, this is not something the patient has the information required to understand. It is a much better experience for the patient.

	Clinical Responsibility	Queries regarding item prescribed now being directed to initiating prescriber rather than via GP or community pharma – easier to resolve and reduced resource to resolve
		Allowing the prescriber to take on the responsibility of the prescription.
	Cost Saving	GP so thankful they do not have to prescribe for lymphoedema garments - must be significant cost saving
Establish communication processes to GPs regarding items prescribed	**Additional admin time for the physiotherapist**	Main issue has been added time due to admin processes (15-20 mins admin). Another layer on patient centre
	GP Practice Responsibility regarding the eTAN	More communication required to ensure GP is aware of their responsibility to pick up treatment
	Communication between primary and secondary care	Main issue is 2 separate systems in Primary care and other services - how live systems are and how they talk to each other - NIECR must communicate effectively with GP systems to reduce workload on both sides
		IT systems where there are mismatches e.g Paris and HCN. If were to continue using HCN, there could be challenges with accuracy. Is this sustainable
		Ensure information that was sent to GP was accurate. Comparison and mismatch reports- flagged by BSO-so any letters that didn't get to GP are alerted and actioned.
	Assistance from Trust IT colleagues	IT have worked closely to ensure processes in place to ensure GP are getting info in timely manner
		(what would you change) Involve IT colleagues from start of project
	Suggestions/Amendments to NIECR	NIECR update would perhaps make admin process more streamlined
		Some changes could be made to patient centre letter to better meet needs of practitioners; repeat prescribing isn't part of the form yet but has to be put into the letter that goes to the GP.
		More streamlined communication system - e prescribing module. need for real time records letter of recommendation were used, do not always know outcome of this

Objectives	Themes	Supporting Extract
Support and enhance the delivery of tailored physiotherapy interventions to patients, maximising professional skills at the point of care delivery	**Utilising skills and expertise**	More timely intervention, decreased error and better use of clinicians skills and knowledge
		Smooth processes have enabled professional skills to be utilised
		Utilising existing skills and expertise
		We are specialists and are able to use those skills appropriately. Timely discharges, timely changes from IV to oral antibiotics.
		It helps staff ensure they are using all the skills they have to improve care for the patients.
		Neurology – beneficial in using skills for slow titration of paint management and spasticity management alongside non-pharmacological interventions.
		Improved learning and collaborative working
	Reduction in errors/delays	Lymphoedema – HS21 ability has reduced errors, omissions, and delays in accessing correct compression garment for patient
		Being able to prescribe reduces the error, provides seamless care and reduces confusion for patients.
		Queries regarding item prescribed now being directed to initiating prescriber rather than via GP or comm pharma – easier to resolve and reduced resource to resolve

	Further opportunities/suggestions to prescribe	Criteria limited respiratory physios to “emergency meds”. (antibiotics, inhalers, nebs-could be extended for non-emergency.) Opportunities missed to provide complete wraparound service e.g. change of inhaler that is not urgent (implement within 72 hrs). Would be useful to explore this going forward.
		Lymphoedema – would like to extend to other medicines in future topical treatments; antibiotics, emollients etc
Support the delivery of care pathways that can be delivered by a physiotherapist	**Highlighting physiotherapist skillset/raising profile**	Raised profile of physiotherapy - value of physiotherapy in MDT - consultants seeking physiotherapy input
		Smooth processes have enabled professional skills to be utilised
		Physio progression to be tested and show value of advanced skills
		Value of physio prescribing highlighted - building relationships with pharmacy colleagues
		Provided an opportunity to increase knowledge and skills of prescribers
		Project has highlighted physio skill set in area of prescribing. Improved profile
		Allowing the prescriber to take on the responsibility of the prescription.
		Improved communication and profile and physiotherapists and NMPs. Covid gave the opportunity
	Reduction in errors/delays	Removes possiblity of transcribing error also. Being able to prescribe directly rather than ask someone else to.
		Lymphoedema – HS21 ability has reduced errors, omissions, and delays in accessing correct compression garment for patient
	Limitations/Suggestions of what could be prescribed in the pilot	Need to address what can be prescribed-controlled drugs especially neuropathic pain
		ICATs did not get maxinum benefit as they are involved in deprescribing
		Limiting of controlled drugs for physio prescribing.

Objectives	Themes	Supporting Extract
Reduce delays in patients accessing medication - greater opportunity to access the right medicines, at the right time, from the right person	**Timely access to medications**	Patients have been able to get the correct garments and often delivered to their home. this can be a difference of 2.5 months via GP to 5-7 days if directly prescribed on an HS21.
		ACAH, pts have been able to get the medications in their homes with help from the families. Patients can get this much quicker than coming from hospital pharmacy and delivering out.
Support a reduction in the amount of unnecessary health care appointments and hospitalisations and promote faster recovery and self-caring	**Reduction in amount of unnecessary health care appointments and hospitalisations**	Acutely unwell patients in respiratory clinic can get urgent medications within 2 hours rather than waiting a few days for urgent care. this can make a difference to whether the patient is admitted to hospital

Support improvements in patient / client concordance with taking prescribed medicines	**Patient Satisfaction/Confidence**	Increases the patients confidence in the clinician.
		Improved satisfaction as patients receive prescribed items sooner.
	Improved Compliance	Lymph- patients used to be very frustrated in the delay, this then led to poor compliance and can affect quality of life and progression of disease. The new system helps the patient have confidence in the system

Appendix 3.2: Common themes encompassing benefits, challenges, suggestions for future pilots and requirements for regional roll-out

Theme	Positives	Negatives	Suggestions for future pilots	Improvements for regional roll-out
Communication/ Engagement	Minimal amount of queries from community pharmacy - as phone numbers were provided any queries could be picked up with prescriber directly	Engagement with community pharmacy sometimes difficult. Some pharmacists did not know about service. More communication with community pharmacy needed. Different methods to be considered.	Use of other methods of communication with community pharmacists	Peer support networks - anxiety around prescribing for the first time, ensuring staff have the appropriate tools to deal with this particularly with high risk medicines
	Invaluable that all stakeholders were involved from the beginning, including GP's and Pharmacists. Zoom has helped facilitate the project in some ways i.e. more stakeholders more easily involved			Communication with GPs to ensure budgetary arrangements are in place
				Streamlined communication e.g. e-prescribing module
Maximising Physiotherapist skillset/Enhancing profile/Training	Provided an opportunity to increase knowledge and skills of prescribers. it helps staff ensure they are using all the skills they have to improve care for the patients.		All specialities from the beginning of the pilot to allow more data.	Consider how prescribing role can have an impact within UG courses

	Excellent collaboration in physiotherapy. Opens up opportunities for other NMPs. Project has highlighted physio skill set in area of prescribing. Improved profile		A sharepoint site for SOP's	Closing the gap between NMP qualification obtained and being able to prescribe
	Removes possiblity of transcribing error also. Being able to prescribe directly rather than ask someone else to.			Standard SOPs and checklists to aid implementation
				As part of training- know the systems and processes at that points to help close the gap between training and practice
				CPD for NMP as a group
	Improved satisfaction as patients receive prescribed items sooner - Satisfying as a professional to see a patient then assess. It emphasises the importance and compliance.			
Collaboration/Project Management	Collective leadership in action			continuation of project management. The oversite and collaborative leadership has been invaluable.
	Improved learning and collaborative working			do we need more local solutions

	Little negatives, excellent collaboration in physiotherapy. Identified what wasn't known.			Apply all the positives from this experience – why this project was successful
Impact of COVID	Zoom has helped facilitate the project in some ways ie more stakeholders more easily involved	Due to the COVID pandemic, some staff involved were redeployed Pilot would have been better in a more stable time with normal staffing levels. Staff redeployed because of COVID therefore less opportunity		
Prescribing Criteria/Controlled Drugs		Restriction of CD legislation for physios involved in pain mgt Interpreted by some prescribers as limited to acute medicines only ICATs did not get maxinum benefit as they are more involved in deprescribing necessity for prescription required within 48-72 hours	Broaden criteria for prescribing	Need to address controlled drugs prescribing. Need to lobby the misuse of CD's guidance

IT related issues: Remote Access/Technical Solution/Mismatch reports/e-prescribing	Trust has now put in place what is required for EDT for future and central point of contact for any mismatch. Being data quality team. Challenges being faced and addressed.	Improved remote access for clinicians in the patients home to ensure allergies etc.		Improved remote access for clinicians in the patients home to ensure allergies etc.
		Bring IT into process sooner to sort out issues as did cause a delay to some starting.		Remote access for clinicians in the southern trust
		Occasionally repeat prescriptions not picked up by GP eg of inhaler prescribed for 4 weeks, repeat not organised		Technical solution to enable remote prescribing, printing of HS21, contemporaneous recording and interface with primary care
				Sustainability of mismatch and include IT from outset, make it work across different IT systems in both Trusts
				Ensuring that all info that is sent to the GP is recorded appropriately for allto see.
				Electronic prescribing and interface with primary care
				Progression of the Etans system.
				Staff have access to appropriate hardware
Policy/ Legislation/ Guidance				Amendment of the legislation, update of the 1992 circular is essential
				Separation of duties for injectors (not strictly related to pilot)

Funding/Resource				Funding needs to be agreed for prescribing activities as pilot rolled out
				Consider some addition resource to support this activity - everything is small scale at present - AHP prescribing governance support will be required in Trust if this grows
Paperwork/Additional Admin work		Timely updating - more time required by physio to complete the admin process		changes could be made to patient centre letter to better meet needs of practitioners
				Avoid duplications with increased awareness
				Optimise management of the gp mis match report
				Optimise Prescribing reports
				Develop a checklist in the appendix going forward
				Standard SOPs and checklists to aid implementation could be helpful. Perhaps bullet points.
Other - Governance/Testing processes etc.	Positive experience on how quickly clinicians implemented it	ST pharmacist felt a little disconnected having come in late to project but raised the issue of pharmacists being aware for medicines reconciliation.	Extra time involved to plan and set up at the outset	Test processes, refine and retest when expanded to new areas (locality and specialty)
			Need to retest processes due to challenged with diff areas and environment	Common governance arrangements across Trusts
			More projects- in other areas. a secondary evaluation with other teams, scaling it up.??	Consistency in governance arrangements
				Good governance around virtual prescribing

Appendix 4: Stakeholder survey results

Appendix 4.1: Do you feel this pilot benefits the patient?

Please provide further details
Reduces delay in accessing urgent medicines Reduces risk of inappropriate compression garment being prescribed Specialist items ae prescribed by specialist prescribers with necessary knowledge and skills e.g. mucolytic clearing devices and lymphoedema garments Reduces burden on GP practices at a time when patients are having difficulties accessing GPs in a timely manner
I know that it will cause us more problems than solve They will all seek our advice and if something goes wrong we will be expected to sort it all out, it's a disaster waiting to happen
Haven't seen any patients involved yet.
there are still some elements to build on to support the physio's in this style of prescribing given the shift in accountability
Not aware of No physiotherapists in practice
I feel that the pilot project did benefit the patient as it streamlined the service for them.
I have only come across one case however can see the potential benefit for patients as waiting time for garments should be reduced
Allows for a more timely response to patient needs, allowing them to get many aspects of their respiratory condition addressed at one consultation with the Specialist Respiratory Physiotherapist. Saves the patient more time and effort when they are already ill -means they do not have to spend considerable time trying to get through to GPs to check if a physios recommendations have been actioned or prescribed and then saves them having to call / a family member call at the practice to collect same.
Reduces time for patient access to medication and reduces urgency for prescription generation from GP practice.
Patient's receiving medications in a more timely matter and more convenient to them when they are acutely unwell. Improved time management in terms of timely discharges and effect use of antimicrobial guidelines ie timely switching from IV antibiotics to oral antibiotics.

I feel it cuts out unnecessary delays in patients receiving their prescriptions given we can prescribe directly from here. Given the massive pressures on primary and secondary care at present, this is crucial to help patients get the right treatment in a timely fashion.
The patient is able to receive the correct medication at the correct time with the least possible hassle
Patients are more informed about their medications and the reason for taking as the physiotherapist is providing a face to face consultation in their own home and follow up to ensure medications are beneficial. I only had the opportunity to prescribe on one occasion due to the limitations on physiotherapy prescribing, however, the advice we give out around medications has been well received by patients and they are reassured by this.
NMP utilises a whole Patient centered care management approach within a context of assessment and management and allows Patients the opportunity to access medication quickly. Also provides the opportunity for Patients to understand how medication is only part of their management and how this can be increased/ decreased depending on their response/ rehabilitation.
I agree with the idea - just haven't seen much impact locally.
Have not been aware of involvement of any of my patients. However, am sceptical.
Not really had much input in our practice
Quicker access to pain relief from physiotherapist
Timely access to prescription items Significant decrease in errors (in fact none so far) Patients understand the process and improved satisfaction with streamlined process
It ensures that the patient receives their prescription in a timely fashion and accurately
Joint visit with the named physio, assessment completed and appropriate garments ordered.
Less mistakes made, garments received more quickly
Quick access to script and medications

Appendix 4.2: Did respondents feel comfortable using the electronic treatment advice note (eTAN)?

Please provide further details
Communication was timely, clear and consistent
Mostly yes, but occassionally there appeared to be issues with GPs receiving/accessing treatment advice notes as some patients reported difficulty re-ordering repeat medications.
Can be time consuming to complete the GP advice notes. Ideally going forward we can utilise E- prescribing which will also automatically update the GP within 24 hrs.
What electronic communication?
Haven't had any physiotherapist electronic communication yet.
However aware that GP surgeries have varying methodologies to manage EDT documents vs postal
See above
Electronic communication allows the practice to generate prescriptions earlier.
I have found this a very seamless approach and helps assure me that the GP is receiving communication re new medications in a timely fashion.
Provides instant summary/report available electronically and reduces physical paper load in practice.
But additional documentation took away from clinical time
I am not a GP so cannot comment.
i feel itowul be useful to have a column on the document to allow a request for the medication to be added to repeats
The assessment was complicated but the GP letter contained all the relevant information
Important for Patient safety and collaborative working
Not sure why it has to be on a separate advice note and not just on the clinic letter.
Not received any
Very little communication through. I asked GPP colleagues throughout Federation and same in all practices. In some practices the GPP sees most communications so this is surprising. We do recall seeing outpatient clinic chits from physio prescribers in the past.
Have not been aware of any electronic prescribing.

Not seen this
As I used letters of recommendation to communicate with GP's I did not use the e-communication
Didn't receive any
I am not aware of any electronic information that is in keeping with HSCB policy of no patient identifiable information,ation on any e mail other that secure mail in the same way as electronic discharge letters are sent and thus visible on ECR
GPs more aware of role of NMP
Yes as the patients can potentially continue on repeat prescriptions so important the GP has the details for their records.
GP updated with regards to the intervention taken for their patients.

Appendix 4.3: Are you happy for the pilot to continue?

Please provide further details
Opportunities to streamline service into business as usual need to be identified and commissioned
Show me evidence it in the long term achieves anything and reduces GP workload, I bet you cannot!
Would like to be shown evidence of how this has been working in practice.
as per advice that continues to be funded and monitored, no further staff added, and build in review of prescribing reporting just recently available vs treatment parameters- e.g. recent report includes non NIF choice PPI.
it should be standard. All AHPs should be encouraged to become Its. It is a scandal that NMPs started in 2005 and no mechanism was found until now to enable these highly skilled professionals to issue scripts that could be dispensed at community pharmacy except through bottlenecking at a GP
I would greatly benefit from continuing to use this approach as i feel it benefits the patient fore mostly but also the physiotherapist in terms of professional autonomy and is the only way I can fully utilize the INMP qualification going forward in the Community Respiratory Team. I fell the practice of directly prescribing as you see the problems is best practice and a gold standard approach to care. The medications on my core formulary lead well to management of patients in an acute exacerbation of their respiratory Condition as well as long term disease management and prevention of hospital admissions.
Beneficial to patients
Has proved beneficial in the whole teams approach to the patient's care.
its been an asset to our respiratory hub clinic.

I think as this service grows this will be a valuable addition for patients and GP's. As demonstrated this is an efficient way for patients to get an assessment and prescription specifically for the issue at the time and follow up to cease or amend this by the same therapist. However, the GP's and the pharmacists based in GP surgery have been fantastic and all letters of recommendation have been followed up in a timely fashion and patients are well managed in this way.
We have had no issues arising from it... a good thing!
Governance and resource (time and money) need given to doctors both in primary and secondary care providing educational supervisor roles. This would be the same as what is provided for training of doctors.
Have not been aware of being involved to date.
There are circumstances where I think it works very well, eg lymphoedema management but in my role I feel that some further changes may need to take place in order for me to prescribe/deprescribe such as the ability to deprescribe controlled drugs, being able to deprescribe via virtual consultations
Haven't seen any significant change in practice
Depends on the method of informing GPs of the medication prescribed
Completes the service delivered by the physiotherapist. Improved governance as the prescription is issued by the person who knows the patients condition the best.
As a district nurse this is a very beneficial service to me. I can rely on the expertise of my colleague which benefits the patient.

Appendix 4.4: What do you think were the positives of this project?

Safer prescribing due to less transcription i.e. physiotherapist issues script rather than asking GP to issue Improved health outcomes as patients are accessing medicines at right time Optimising the skills of non-medical prescribers Established electronic communication with GPs Supported GPs during Covid pandemic
Faster access to time critical medication, reduced steps in the prescribing process and prescribing decisions being made by specialist staff.

Highlights that fact that Physio NMP can safely prescribe using the HS21 pads. Patient feedback shows the impact /benefit to the patient - more timely access to required medication during an acute episode.
None.
interface prescribing is a system issue that is not patient centred, this project is more patient centred
quicker drugs for pts w/o having OPD advice notes having to be processed through GPs less prescribing by physios than by GPs who have little else to offer CCFNs beginning to understand that CCF meds titration requires rescuers and isn't always achievable
Not aware of Would be concerned this is yet another risk of the watering can effect in GP. In that this is conceived in good faith to try and alleviate pressure in GP yet in reality actually increases work in terms of long term prescribing ,"updating " records , identifying issues that the patient " needs to see their GP for other minor comments , managing complications etc etc
No delay in patients receiving prescriptions. No confusion regarding intentions of prescriber from relevant clinic.
Patient received medication in a timely fashion and from the person who directly assessed them.
streamlining of the service less waiting for the patient quick start to treatment- efficient
Lymphoedema prescriptions can often be quite complex, requiring inclusion of several codes. The absence of/inclusion of incorrect information can lead to a delay in the correct garment being supplied to the patient. Physiotherapist prescribing should mean the patient receives the required garment sooner. -Physiotherapist prescribing can minimise transcribing errors and avoid unnecessary expenditure. With soo many similar garments available for selection on practice clinical systems there have been occasions were the wrong garment has been selected.
More timely response to patient care. More professional autonomy. Enablement of full use of iNMP prescribing qualification rather than only being able to make letters of recommendation. Better time management - avoids having to wait prolonged periods of time to get through to a GP practice) this is worse now than ever with COVID) and a big issue for us in the community as we do not have direct tines to GP practices. Better engagement and awareness of community Pharmacy and building relationships with other colleagues such as GPs /

Community Pharmacists - promoting the Physiotherapy profession. Enables an approach such as that of first contact physio practitioners for the field of respiratory care.
Beneficial to patients, no delay in access to medication
Faster access to medications. Specialist practitioner prescribing rather than recommendation letters which leaves exact prescription at the discretion of GP.
Improved service for the patients Enhanced skills for physiotherapists ensures other staff had more time to see more patients and improved capacity for the team
Appropriate prescriptions received in a more timely fashion. Patients get meds quicker, skips the step of requiring a GP to prescribe. I would be keen for this to continue
Huge benefits to the patients. quick and effective treatment is urgent circumstances Very rewarding for the clinician, able to use their extended scope skills for the benefit of the patient. Putting all their training into action.
Patients got advice at the time of assessment and follow up within a few days in their own home - a comfortable environment . They were seen by a therapist face to face and felt that they could ask questions and there was more time to discuss side effects and usage.
Patient access to medication/ garments at the time most likely to benefit to maximise Patients ability to respond to their Physiotherapy intervention. Staff using their skills and working at the top of their licence. Inter-professional collaboration with operational and Governance issues across the systems.
Allows patient to get their medication in a timely manner and relieves burden on GP practice.
reduced bottlenecking of prescription requests at the GP empowering AHPs and Independent Prescribing nurses
Lymphoedema physio rxing has potential huge benefits as selection of complex stocking requirements better to stay with them as experts and who have measured. Respiratory physios - if completing HOOF oxygen Rx very useful.
I presume patients have had easier access to their medicines and it has helped titrate doses - but haven't seen evidence of this in practice.

Stops doctors being the bottleneck in getting prescriptions and therefore improves the service to patients. Enhanced team working with other clinicians who are by and large excellent.
Early prescription of acute medications and specialist garments/items for patients Improved autonomy and better use of staff skills
Not aware of the project happening. Therefore, not aware of any benefit.
I feel that there could be benefits to patients especially when they are having difficulty seeing their GP's at present, so they can get advice on appropriate medication in a timely way. I feel that my main role with prescribing will actually be de-prescribing on medication that the patient may no longer require/be safe to continue with/not appropriate for their condition
Saved workload and unnecessary hassle for GPs to prescribe when physios were suitably capable.
LESS TIME WASTED
Ability to prescribe acutely without the need to have to do this via GPs
Quicker access to prescription items Decreased errors in prescriptions Improved outcomes for patients due to seamless process less admin time spent for clinicians trying to contact GPs, pharmacists etc Improved job satisfaction
Quicker access for patients to compression garments, quicker prescribing, reduced delays with queries, reduction in transcription errors, reduced telephone queries when GPs struggle to find items on their system. Less queries in general from the patient into the clinic saving the clinic time.
Learning from other disciplines and apply this knowledge to my practice.
service user receives correct garments in a more timely way
Benefits that the patient received the script quickly and therefore could go straight to pharmacy to purchase medications.

Appendix 4.5: Challenges/Negatives of the pilot project?

Establishing electronic communication with GPs Engaging community pharmacists

Mostly communication between primary and secondary care was smooth. Main issue is the increased admin time with completing the HS21 and audit trail, treatment advice note, giving out patient feedback survey on top of other existing admin processes.
Time management- Increased admin time to complete Gp advice notes and additional time required to record prescribing data for the pilot.
Early in development, so further angles to scope e.g. electronic HS21's, better systems of access to appropriate patient records prior to prescribing, further prescribing support.
because of a legacy of OPD advice notes meaning GP prescription perhaps there needs to be a clearer way to flag these notification of IP non-GP scripts as "for info only" at this time rather than risk confusion as prescription requests of GP
Ensuring follow up bloods have been arranged with patients. If there was a compliance issue that the patient didn't mention during clinic a script could be issued for a change in medication that was potentially not needed.
Didn't get my prescription pad until last month of pilot. The patient's I saw were not requiring the emergency medications, many already on it or was oxygen that was prescribed which wasn't being recorded in the audit.
Nil
No challenges encountered
No direct access to NIECR and BNF app / micro guide app on the IPADS we normally use for our home visits- this means we are not able to prescribe medications often in the home setting as we are not able to check the 2 sources of allergy history to enable safe prescribing.
Not aware of any
Documentation / additional time away from face to face clinical time
Working within scope of practice, at times still need to use hospital pharmacy for anticipatory meds for example. COVID has been challenging
Extra admin time required.
nil
The biggest challenge to physio is the restriction in the type of medication we are able to prescribe/deprescribe and this hampered a lot of changes to medication. Specifically within ICT a large number of patients have compliance aids which are best managed from GP surgery.
eDTAN solutions Communication with the wider stakeholders around changes to NMP by Physiotherapists
Knowing what is available in community pharmacies and extra admin duties for prescriber.

it's still niche so easy for messages to be confused and gPs to think they still need to prescribe on foot of communication from Trusts
Limited range of products able to be prescribed by project. ICATS team also has medical input so limited use for NMP
None - but haven't seen any communications through so that could be a concern just not seen yet.
Governance as above. Physio consultants exist and have a management role largely- therefore why would they not do nmp sign off if there wasn't finance/time provided for doctors to do it? The same applies to other clinical areas. A clear structure and educational pathway is needed in each clinical role so that staff and supervisor know where they are at. Graduate nurse, treatment room/ward nurse, GPNurse, NMP, ANP & nurse consultant. Clarity of pathway & governance would improve things for all and improve recruitment in the long run.
data transfer, limitations within the legislation for prescribing
As stated before have not been aware of the pilot happening.
At present due to trust policies with covid-19 we are completing a large volume of our consultations virtually and CSP currently do not recommend that prescribing is done virtually except in a limited amount of cases, none of which really apply to our cohort of patients
Governance, both clinical and data
Time constraints, increased time spent on prescribing needed slotted into day which was already busy with patients, diaries needed amended to account for same
Balancing the additional admin time for the clinician as some of the previous admin time associated would have been carried out by assistant staff. Checking if prescription had been raised, pharmacies ordered, checking if letter of recommendations had been correctly transcribed. So this has saved assistant staff time to be used elsewhere in teh clinic setting
ensuring gps were made aware of he prescribing decisions
In the SHSCT we don't have access to NIECR on our ipads so unable to check allergies etc.

Appendix 4.6: What improvements/considerations should be made for full implementation?

Commissioned service to provide necessary resource to ensure appropriate governance in employing organisations
At present shared learning and communication with other trusts would be key for further roll out.
Education of GP's that NMP's now using HS21 pad and to follow-up on info given on GP advice notes. Ideally- develop/utilise and electronic prescribing platform to streamline processes.
It shouldn't be implemented. More focus on non drug options and pain management ' psychological approaches
Don't know
the current arrangements of the memorandum of understanding from 1992 do not fit this model of prescribing, and whilst changes are required to enable those could have far reaching implications for other changes- not all those involved in NMOP prescribing will perhaps have that vantage point
political will to do something about GP workload less infighting by Trusts that this belongs to GP prescribing budgets - it is all the one pot of money
I would imagine finding - no physiotherapist s working in Gap in East Belfast The other problem is actually physical space in surgeries to accommodate this Physiotherapist working in GP should be a well experienced physio who can work independently without recourse to GP. And is managed supported by their employers not GP - I would recruitment of this calibration if Physio will be an issue as the physio schools have not increased their numbers in the past 10/15 years to facilitate this.
Southern trust requires remote access for their ipads to be able to access NIECR for allergies/alerts etc.
Full NIECR / BNF . Micro guide access on trust IPADS in Southern trust - I have now applied for this 3 times and it has still not been sorted out for me.
Not aware of any
Electronic recording of prescription rather than GP advice note. More training for staff on use of HS21 prescription pads. More awareness to other professions and doctors of pilot and its outcomes/feedback.
Improved remote access Improved team interaction
policy changes required legislative change
Better internet access so that assessments could be implemented in the home. Also need access in the community to ECR and results so that informed decisions could be made at the time re medication prescription when in the home.

Controlled Drugs legislation for Physiotherapists limits prescribing/ deprescribing. Ensuring Trust readiness for the implementation of this model and the governance around this both professionally and operationally. Firm commitments around NMP budgets for trusts. Electronic prescribing solution that is fully operational with Primary care.
Make admin more streamlined Ensure prescribers are fully trained how to prescribe on prescription e.g. must state how many to supply, pack size etc.
doing this at scale rather than niche projects - although I appreciate pilot projects are required
Extension to more specialties and meds NIECR updates to issues of medications
Nothing to add as haven't experienced impact locally.
Challenges seem to be the piece meal way in which it is being introduced plus the ridiculous number of pilots of all sorts of different projects - the right hand doesn't know what the left is doing.
A role out of an efficient/effective e-system that can be accessed to update patients drug records, that could flag interactions, adverse effects from previous drugs and which can be accessed by GP so all drug information on each patient is kept in the one place Also a look at the legislation to enable physio to prescribe/deprescribe controlled drugs
Sufficient numbers of trained staff.
Number 5 clarified
joint working between disciplines from each trust to enhance learning and demonstrate new models of practice
Role out of governance procedures on a regional basis. Refresher training for those who have completed training but not yet used HS21.
If there a way to have prescribing online without needing to write and post paper prescriptions
We need access to NIECR on ipads in SHSCT.

Appendix 4.7: Additional Comments

Good example of how collaborative leadership can benefit patients

ultimate goal of electronic prescribing would be ideal.
I have no doubt thus will be mothballed
Would have thought it should have been scaled up a step further to more pilots than current format before it proceeds to full implementation. There was a huge amount of interest in this style of prescribing by specialist pharmacists regionally and this was highlighted post engagement by HPMM. Pharmacists are more experienced with the systems and governance across HS21 prescribing, many have more prescribing experience but no opportunity to participate within the pilot.
See above Unfortunately have no knowledge of actual working of scheme otherwise would be happy to comment further Resources to train physios s as independent prescribers might be better used as to be honest I see no real benefit in this other than injectable steroids and simple analgesia and who ultimately takes the risk of a complication from a drin interaction.
I feel that this pilot has been beneficial both for staff and patients. I have seen it useful particularly when prescribing nicotine replacement therapy/inhalers whilst the patient has been attending a clinic appointment.
I was delighted to be a part of this project and would be so disappointed if we were not able to continue with this practice given the documented benefits. I have had great personal feedback from Patients / family members and my own respiratory team colleagues. I feel strongly about having the ability to promote your profession and these practices certainly pave the way for future Physiotherapists - I hope.
Any systems or projects that provide better integration between services are always beneficial and a step forward.
Excellent project and very worthwhile improvement in the patient's care.
a wonderful opportunity for physiotherapists. Led by a fantastic team,
Brilliant transformative project that realised the potential of Physiotherapists to utilise their Non Medical Prescribing Qualifications for Patient's benefit!
Great initiative which I think should be expanded to all areas.
It would be useful to see numbers of patients who have used the service, their outcomes and where in the SE locality this has occurred - as we have seen little impact (discussed with GPP team).
Generally positive The above comments echo discussion with secondary care colleagues at SETrust clinical leaders meeting recently.

You have got me on a bad day. I cannot keep up with all the different projects and pilots. I was not aware of this one and I don't see it reducing my work load.
Sorry, I have had little experience of this pilot so feel unable to comment
Personally this has been very satisfying to be part of. Delighted to see NMP in action and the benefits that it brings.
very beneficial
Would be good if could continue for not only acute meds but inhalers and other non-acute meds.

Appendix 5: Process Maps

Appendix 5.1: Pre and Post Process Map for NMOP Physiotherapy Pilot - Orthopaedic ICATS

Process for obtaining medicines pre NMOP

1. Patient assessed
2. Are medicines or medication changes required?

Next step in pathway dependent on nature of medication/change as summarised in below:

3a. Injection for administration by physiotherapist administered as per PGD	3b. Deprescribing medication – complete eTAN and verify - sent by EDT to GP	3c. New Medicine required: Letter of recommendation to GP
	4b. Advise patient to reduce dose	4c. GP reviews letter of recommendation
	5b. GP reviews eTAN recommending reducing dose	5c. GP writes prescription
	6c. GP writes script for reducing dose	6c. Prescription taken to community pharmacy
	7c. Prescription taken to community pharmacy	7c. Community pharmacy dispenses prescription
	8c. Community pharmacy dispenses prescription	8c. Medication collected by / delivered to patient
	9c. Medication collected by / delivered to patient	

Total timescale: 1-7 days

Issues with current process

1. Risk of errors
2. Delay in actioning medication change / request at GP practice
3. Patients that are referred to this service have usually been 'worked-up' in terms of basic pain management, therefore, opportunities to make a medication recommendation are limited. Patients are often past the acute phase of illness at time of appointment e.g. chronic pain management associated with spinal fusion. There is greater opportunity for physiotherapist to recommend that medication is stopped / tapered

Process for obtaining medicines as part of NMOP programme

1. Patient assessed
2. Are medicines or medication changes required?

3a. injection for administration by physiotherapist administered as per PGD	3b. Deprescribing medication – HS21 for reducing dose issued if appropriate	3c. Prescribe new medication on HS21
	4b. Advise patient to reduce dose if appropriate	4c. eTAN completed to inform GP
	5b. Prescription taken to community pharmacy if appropriate	5c. Prescription taken to community pharmacy
	6b. Community pharmacy dispenses prescription if appropriate	6c.Community pharmacy dispenses prescription
	7b. Medication collected by / delivered to patient if appropriate	7c. Medication collected by / delivered to patient

Total timescale: 1-4 days

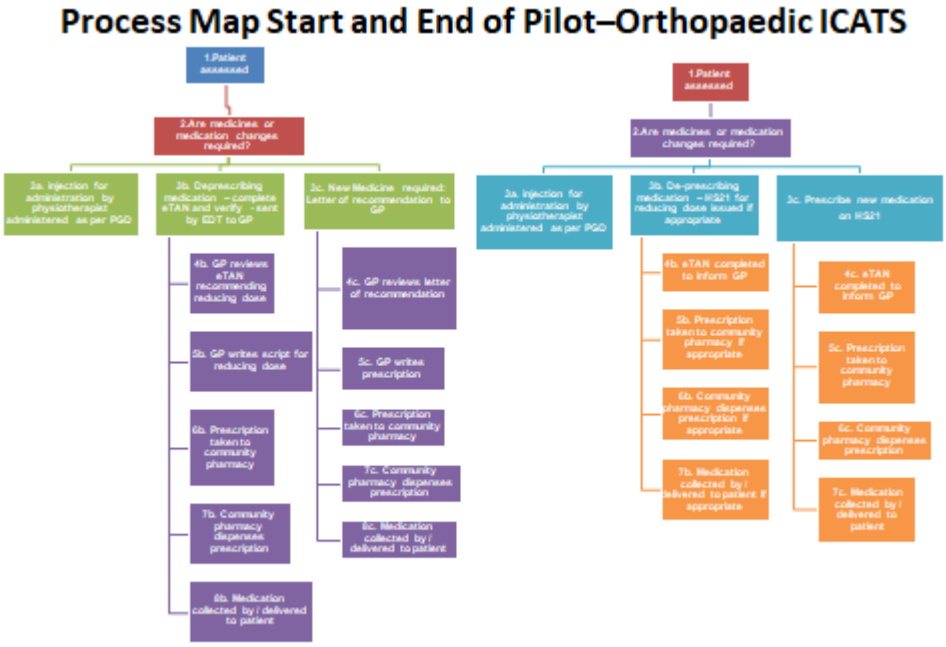
Issues with new process

1. Time to handwrite prescription
2. Time to document on patient centre
3. Record keeping for evaluation purposes (need for this will be removed when service becomes business as usual)
4. Patients that are referred to this service have usually been ‘worked-up’ in terms of basic pain management, therefore, opportunities to prescribe using HS21 are limited. Patients are often past the acute phase of illness at time of appointment e.g. chronic pain management associated with spinal fusion
5. Limitations of Controlled Drug regulations for physiotherapist prescribers e.g. MSK and orthopaedic patients often prescribed strong opioids, gabapentin, pregabalin which currently are not prescribable. In some cases prescriber may be able to deprescribe a medicine e.g. amitriptyline, but be unable to commence an alternative e.g. gabapentin
6. Redeployment of ICATs orthopaedic physiotherapists to support COVID pandemic response

Benefits of intervention

1. Reduced error rate
2. Reduced delay in patient receiving prescription
3. Reduced workload for GPs to process prescription request
4. Specialist is writing prescription
5. Reduction in physiotherapist time required to follow up prescription requests which increases capacity for clinical work
6. Opportunities to deprescribe medication once non-pharmacological intervention commenced

Appendicies_An Evaluation of New Models of Prescribing (NMOP): A Physiotherapist Prescribing Pilot_Final



Appendix 5.2: Pre and Post Process Map for NMOP Physiotherapy Pilot Respiratory

Pre Pilot – Steps Involved

1. Patient assessed (Community or Clinic)
2. Decide if medicines or changes to medication including de-prescribing are required? *(if community, physio will ring GP and GP will ring the patient)*
3. Letter of recommendation delivered to GP or telephone practice to request call back from GP
4. GP reviews letter of recommendation or GP returns call
5. Telephone follow up with patient
6. Telephone update with practice on progress of prescription
7. GP writes prescription
8. Prescription collected by patient or community pharmacy
9. Community pharmacy dispenses medication
10. Medication is delivered or collected by patient

Total timescale = 4-7 days

Issues with current process

- Delays in patient care
- Transcribing errors
- Adds to GP time when the physio has the qualifications/skills to write the HS21
- Time taken to write letters of recommendation and telephoning GPs for prescription
- GP may return call at a much later stage which increases risk of error, or when the physiotherapist is unable to accept to call due to poor signal etc
- Policy revision is required to allow the service to become Business as Usual. The relevant policy is currently out for Ministerial consultation.
- NIECR is not a live system – need a system to enable access to up to date allergy information and alerts.

During/After Pilot – Steps Involved

1. Patient assessed (community or clinic)
2. Is a prescription required?
3. Physiotherapist writes HS21
4. Physiotherapist completes eTAN
5. Prescription taken to community pharmacy
6. Community pharmacy dispense medication
7. Medication is delivered or collected by patient

Total timescale = 1-3 days

Issues with new process

- Time to handwrite prescription
- Time to document on patient centre
- Record keeping for evaluation purposes (need for this will be removed when service becomes business as usual)
- NIECR is not a live system – need a system to enable access to up to date allergy information and alerts.

Benefits of new process

- Reduced workload for GPs
- Reduces delays in obtaining medication – patient can have obtain their medications within an hour of their appointment
- Physiotherapists can use their specialist knowledge for medications i.e. which device or category of nicotine replacement therapy is required
- Reduction in physiotherapist time for follow up which increases capacity for clinical work
- Reduction in transcribing errors
- Possible prevention of hospital admission due to early access to urgent meds
- Prevent deterioration of condition
- Every contact counts with regards to smoking cessation intervention and opportunity.

Process Map Start of Pilot– Respiratory

Process Map End of Pilot– Respiratory

Appendix 5.3: Pre and Post Process Map for NMOP Physiotherapy Pilot Musculoskeletal

Process for obtaining medicines pre NMOP

1. Patient assessed (domiciliary or outpatient)
2. Are medicines or medication changes required?
3. Letter of recommendation delivered to GP **OR** Telephone practice to request call-back from GP
4. GP reviews letter of recommendation/ GP returns call
5. GP writes prescription/ Patient may require GP appointment before prescription is actioned.
6. Prescription collected by patient or community pharmacy
7. Community pharmacy dispenses prescription
8. Medication collected/delivered to patient

Total timescale - 4-7 days

Issues with current process

1. Risk of errors, miscommunication in handover of information, medication, dosage, strength, quantity etc
2. Delay in issuing medication change / new request
3. GP may not wish to action letter of recommendation
4. GP's may wish to review patient themselves prior to writing prescription therefore further delay in receiving medication.

Process for obtaining medicines as part of the NMOP programme

1. Patient assessed (domiciliary or outpatient)
2. Are medicines or compression garments required?
3. Physiotherapist writes HS21 recorded within Patient electronic record
4. Physiotherapist completes eTAN
5. Prescription collected by patient or community pharmacy
6. Community pharmacy dispenses prescription
7. Medication collected by / delivered to patient

Total timescale: 1-4 days

Issues with new process

1. Time to handwrite prescription
2. Time to document on patient centre/ Paris and complete ETAN
3. Record keeping for evaluation purposes (need for this will be removed when service becomes business as usual)

4. Waiting times e.g. a patient who self-refers to Core MSK services will have to wait 4—13 weeks for an appointment, or if considered routine will be added to a waiting list, by which time they will have usually sourced analgesia.

Benefits of intervention

1. Reduced error rate; prescription will be individual to Patient's clinical presentation and as part of the Physiotherapy management. Prescription will be short term and can be titrated depending on Patients response to Physiotherapy. Potential to reduce side effects and additional need for further medication or timely review in managing side effects from medication. Patients medication is incorporated into Patient's GP and Physiotherapy record and shared on NIECR for future reference.
2. Reduced delay in patient receiving prescription
3. Reduced workload for GPs; time taken to contact Physiotherapist, review Patient record, consult with Patient and issue prescription.
4. Specialist Physiotherapist is writing prescription
5. Reduction in physiotherapist time for follow up on supply issues, which increases capacity for clinical follow up e.g. review effectiveness of prescribed medication
6. Patients receive active Physiotherapy assessment, management, medication and review. Therefore there is the potential to reduce prescribing costs and optimise pain management.

Process Map Start of Pilot – Musculoskeletal

Process Map End of Pilot– Musculoskeletal

Appendix 5.4: Pre and Post Process Map for NMOP Physiotherapy Pilot Respiratory: Acute Care at Home

Pre Pilot – Steps Involved

1. Patient assessed within 2 hours of referral
2. Discussion at MDT (12pm) OR if patient assessed in afternoon then discussion with doctor by phone
3. Patient script to be written when prescriber returns to base
4. Scanned to hospital pharmacy
5. Pharmacy advise when medication will be ready – time required depends on how busy pharmacy is (30-120mins)
6. Medication delivered to the patient by nursing staff when making next call (afternoon or evening call)
7. Kardex updated or family advised by phone on administration instructions

Total timescale = 4-12 hours depending on staffing levels/ travel times

Issues with current process

Time taken for hospital pharmacy to prepare and dispense medication

- Dependent on business of pharmacy and staffing levels
- If an AC@HT pharmacist is on duty then process is faster
- Extra time required is for controlled drugs due to additional checks required

During/After Pilot – Steps Involved

1. Patient assessed within 2 hours of referral
2. HS21 issued by physiotherapist prescribe
3. Family member takes script to local chemist OR Script taken to community pharmacy
4. Community pharmacy dispenses
5. Medication collected/delivered to patient

Total timescale = 1-7 hours depending on availability of family member and distance to community pharmacy

Issues with new process

- Patients are acutely unwell and unable to attend to community pharmacy themselves and therefore rely on family members or pharmacy delivery service.

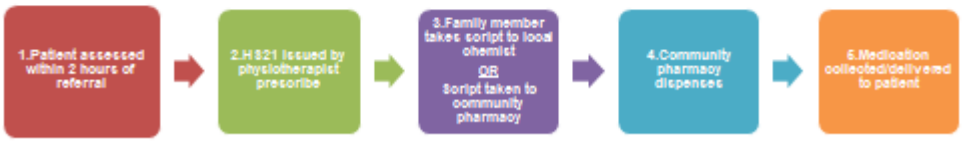
- Patients may require s medications outside the physiotherapist's parameters of prescribing (e.g. controlled drugs / fluids) and, therefore, they have to get prescriptions from hospital pharmacy.

Benefits of new process

- Shorter time between decision to prescribe and patient receiving medication
- Ability to educate the patient in their own home and provide the script
- Patient and families have improved confidence in professional ability
- Much more beneficial for patients who live furthest from hospital base in obtaining medications faster
- Enables physiotherapist prescriber to discharge some patients from AC@HT instead of nurse. Nurse discharge would involve waiting for oral medicines to be dispensed by the hospital pharmacy and then delivering medicines to the patient. This frees up nursing capacity to process new admissions to the service, avoiding presentation at ED or admission to hospital.
- Ability to switch IV antibiotics to oral antibiotics in keeping with antimicrobial guidelines.

Process Map Start of Pilot Respiratory: Acute Care at Home

Process Map End of Pilot Respiratory: Acute Care at Home



Appendix 5.5: Pre and Post Process Map for NMOP Physiotherapy Pilot Respiratory – Lymphoedema

Pre Pilot – Steps Involved

1. Patient assessed (domiciliary or outpatient)
2. Are medicines or compression garments required?
3. Letter of recommendation delivered to GP
4. Telephone follow up by prescriber to ensure prescription is processed in practice
5. GP writes prescription
6. Prescription collected by patient or community pharmacy
7. Community pharmacy orders item
8. Supplier delivers item to community pharmacy
9. Medication collected/delivered to patient

Total timescale - (compression garments 3-6 weeks, medicines 4-7 days)

Issues with current process

Risk of errors with compression garments;

- Size
- Style
- Class (strength)
- Quantity
- Colour
- New letters of recommendation to be written and process repeated

Delay in obtaining correct compression garment

- Interim bandaging required until compression garment is available which is associated with costs of bandaging and district nursing time

During/After Pilot – Steps Involved

1. Patient assessed (domiciliary or outpatient)
2. Are medicines or compression garments required?
3. Physiotherapist writes HS21
4. Physiotherapist completes eTAN
5. Prescription delivered to supplier (community pharmacy or DAC)

6a. Community pharmacy orders item
6b. DAC delivers item to patient

7. Supplier delivers item to community pharmacy

8. Medication collected/delivered to patient

(DAC = 6 steps, 8 = Community Pharmacy)

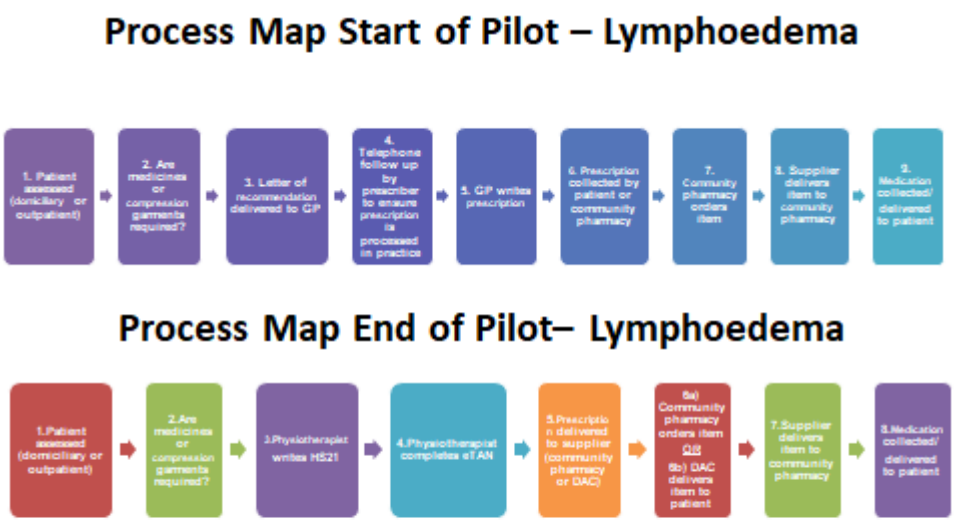
Total timescale - (compression garments 7-10 days, medicines 1-4 days)

Issues with new process

- Time to handwrite prescription
- Time to document on patient centre
- Record keeping for evaluation purposes (need for this will be removed when service becomes business as usual)

Benefits of new process

- Reduced error rate
- Reduced delay
- If using DAC, prescriber is informed of order progress
- Reduced workload for GPs
- Specialist is writing prescription
- Reduction in physiotherapist time for follow up which increases capacity for clinical work
- Assurance that patient has received items
- Reduced district nursing time for interim bandaging



Appendix 6: Patient Journeys

Appendix 6.1: SET Respiratory

Patient presented late on Good Friday afternoon

- 78yo female
- No known respiratory history
- Presented to Emergency Department 1 week previous with SOB/wheeze/cough
- Discharged with salbutamol inhaler and 5 day course of oral steroids
- Feeling improved but steroids just finished
- Moderately obstructive spirometry and slight expiratory wheeze
- History in keeping with new diagnosis of late onset asthma
- Prescribed Fostair 200/6mcg two puffs BD with spacer on HS21
- Patient was able to get medicine dispensed and collected from community pharmacy on Friday evening before a 4 day bank holiday weekend
- This intervention may possibly have avoided OOH or A&E re-attendance during the Easter holiday period.

Appendix 6.2: SET Respiratory

Involvement of respiratory physiotherapists in the rehabilitation of COVID patients during the 3rd surge:

As part of the Regional NMP pilot two physiotherapist prescribers issued approx. 150 prescriptions to patients attending the Ambulatory Respiratory Hub (UHD) by 16th April 2021.

Although they reviewed more than 50 patients for post covid pneumonia follow-up as per BTS guidelines- most of these patients didn't require prescriptions for medications. Instead, treatment usually involved education on management of long covid symptoms and then signposting for appropriate follow-up. This follow-up would often include Post Covid Pulmonary Rehab, Dysfunctional Breathing clinics. If the patients had other underlying chronic chest conditions that required optimisation, or if they suffered from other co-morbidities worsened by covid eg. GORD then prescriptions were issued by the physiotherapists.

Since the start of our NMOP pilot and throughout the recent Covid Surge the two prescribers continued to treat patients referred from GPs , Community Respiratory Teams, A+E, hospital wards with a view to preventing hospital admission and facilitating earlier hospital DC. This included treating patients with acute respiratory conditions such as pneumonia and to help manage acute exacerbations of chronic respiratory diseases such as asthma, COPD, bronchiectasis, interstitial lung disease

etc.. Having their own HS21 pads has enabled them to work independently and ensured that their patient's received their acute medicines in a timely manner without having to go through their GP practice. Verbal feedback from patients has always been very positive when they realised they can go direct to the pharmacy to collect their medication.

Between Nov- Feb 2021 see below:

- No. of Covid patients treated in the Respiratory Hub(UHD) = Min.50
- No. of patients with COPD and Asthma treated in the Respiratory Hub(UHD) =250

Appendix 6.3: Respiratory – smoking cessation

This lady presented to ED on 27/3/21 with acute worsening SOB, cough, wheeze, clear sputum on a background of 5 years gradual worsening symptoms. Smoker with > 20 pack yr history. No formal respiratory diagnosis.

She was assessed in the respiratory hub as an IP 30/3/21 - Initially thought possibly COPD as spirometry moderately obstructive but on review appointment at 6 weeks she was feeling great, no respiratory symptoms at all, spirometry fully reversed to normal and had stopped smoking having been prescribed Nicorette invisipatch 25mg/16 hrs and Nicorette gum 2mg/piece (max 15 pieces daily) and referred on to smoking cessation service. Likely new asthma diagnosis.

Appendix 6.4: ST Lymphoedema

- Patient receives garment in more timely fashion. In some cases 1 week from assessment to getting garment. Previously could commonly take 4-6 weeks+
- Fewer errors in transcription from letter of recommendation to prescription.
- Less delays in requests waiting to be actioned at GP surgery
- Any supply issues (Brexit/Covid related) are communicated directly to physiotherapist prescriber
- Any queries come directly to us and resolved immediately, previously these were in the 'ether' or delayed as would go back through community pharmacy to GP and then to us.
- Time saved in clinic dealing with queries from GP, practice pharmacists and community pharmacists, and queries from patient particularly when orders were delayed
- Patient's prefer NMP ordering, "I'd rather you do it, you know what I need" especially at the minute with less GP contact

- For those with limited social support or during remote consultations we can post the prescription and have garments delivered directly to the patient or to the clinic for fitting
- Garments arriving quicker ensures faster throughput in clinic (those attending for bandaging need to continue until garment arrives which has bandage and community nursing costs associated with it)
- Cases co-worked with district nurses enable the patients to get into garments much quicker to reduce number of domiciliary visits while waiting compression hosiery
- Most HS21s issued by lymphoedema physios have been sent directly to a dispensing appliance contractor - it help facilitate remote consultation, to accommodate the patient and also with reduced clinic space but because of the complex nature of what we are prescribing we can take our time to get it right rather than have the patient sit and wait for it

One example of delays that can be faced: one physiotherapist does not have children included in her parameters of prescribing so any recommendations relating to paediatrics still go to GP for implementation: Delay in prescription issued by GP = 43 days from consultation with physio. Comm Pharmacy ordered garment from company. Garment was lost by courier and had to be reordered by community pharmacy. Patient's mum was following up with GP and community pharmacist, so lymphoedema physiotherapist did not know there was an issue. Once physiotherapist was made aware it required 30 minutes of their clinical time to check NIECR, phone GP/CP and patient's mother.

Appendix 6.5: ST ICATS

MSK physios involved in ST ICATs service were unable to write any actual prescriptions during the data collection period. There were a number of factors which have led to this:

- Not an acute service and therefore service users do not require an urgent, within 72hrs, change in medication as they are often dealing with long term chronic issues
- There was a significant decrease in activity, in general, during the pilot period in ICATS MSK physiotherapy due to re-deployments and service reduction secondary to COVID
- Reduced ability to prescribe/de-prescribe "virtually". Majority of consultations are via telephone.
- The opportunity to prescribe virtually in ICATS is limited. The CSP 2021 advise the prescriber should have sufficient information to make a safe prescribing decision. In ICATS diagnosis is based on both subjective and

objective findings. This will be applicable to areas such as the diagnosis of neuropathic pain or a diagnosis an acute inflammatory response. This limited the ability to make changes to prescribed drugs or start new drugs in ICATS during the COVID period.

- Due to the chronic nature of some of the service users' conditions there is potential for physios involved in this service to de-prescribe some of their medications that patients no longer require or need to stop due to possible detrimental effects on their health. Unfortunately, as some of these drugs are controlled drugs (e.g. gabapentin, pregablin) physiotherapist prescribers are unable to prescribe due to current legislation. This limits the ability to reduce dosing and de-prescribe.

Physiotherapist prescribers involved in this service continue on a regular basis to advise both the patient on their medication and write letters of recommendation to the GP to identify areas where potential prescribing and de-prescribing are required

Appendix 6.6: SET ICATS

A 75 year old patient currently prescribed warfarin presented. Medication history uncovered that patient had been taking ibuprofen 400mg three times daily – patient's daughter had been purchasing OTC. Patient was urgently advised to discontinue and physiotherapist contacted patient's GP by telephone to inform.

Appendix 6.7: ST ICATS

MSK physios involved in ST ICATs service were unable to write any actual prescriptions during the data collection period. There were a number of factors which have led to this:

- Not an acute service and therefore service users do not require an urgent, within 72hrs, change in medication as they are often dealing with long term chronic issues
- Unable to prescribe/de-prescribe "virtually". Majority of consultations are via telephone.
- Governing body (CSP) has stipulated that prescribing cannot be done virtually.
- Due to the chronic nature of some of the service users' conditions there is potential for physios involved in this service to de-prescribe some of their medications that they have no longer require or need to stop due to possible detrimental effects on their health. Unfortunately, as some of these drugs are controlled drugs (eg. Gabapentin, pregablin) they we are currently unable to deprescribe due to current legislation

Physiotherapist prescribers involved in this service continue on a regular basis to advise both the patient on their medication and write letters of recommendation to the GP to identify areas where potential prescribing and de-prescribing are required – see examples below by way of illustration

Patient 1

44 yr old lady had been referred as an Urgent to Ortho ICATS from her GP. She had 6/52 hx of LBP but more significant R leg pain to foot. She had been prescribed co-codamol 30/500mg (up to 8/day) by her GP and Naproxen 500mg BD.

She presented with acute nerve root pain in her R leg as far as her foot with associated paraesthesia. She was struggling to cope as wasn't sleeping at night and had a young family. She was having difficulty tolerating her medication due to GI upset and constipation and felt they were of limited benefit anyway. She was avoiding taking the co-codamol and had reduced her naproxen to 1/day.

On examination she had a reduced SLR but a normal neurological examination. She had trialled 1-2 sessions of private physio but she felt that this had aggravated her leg pain she hadn't scheduled another appointment.

The Ortho ICATS non-medical prescriber sent a letter of recommendation to her GP to advise starting a neural analgesic, in the first instance amitriptyline 10mg at night, as there were no CV risk factors. This could be titrated up to 20mg at night if felt required by patient. Advice was given re possible increased risk of sedation.

The letter of recommendation also advised to reduce co-codamol 30/500mg to trial 8/500mg (up to max 8/day) to reduce the side effects from codeine and also to provide a PPI cover of the GP's choosing to take in conjunction with the naproxen.

The patient reported within a week a much improved sleep pattern initially taking amitriptyline 20mg a nocte. This gave her the ability to cope much better through the day and she was able to then comply with physiotherapy. Her nerve root pain settled well with physiotherapy intervention and she was able to gradually reduce her amitriptyline intake completely after 8/52. She was advised how to slowly reduce her intake over a period of 10/7.

She had some residual back pain which was present prior to her acute flare and managed this by exercising and taking paracetamol PRN when she felt it more uncomfortable.

Patient 2

64 year old lady who had been prescribed gabapentin 2700mg/day spread over 3 even doses for chronic LBP but referred nerve pain.

She was referred to Ortho ICATS for the management of her back pain as she felt that all other conservative measures had failed.

On examination she had globally reduced ROM of her lumbar spine, particularly into extension, reproducing her R sided lower back pain. She had normal SLR and normal neurological exam.

The patient's main complaint was that she was no longer able to exercise the way she once had. She felt previously that had helped manage her back pain but she had 2 years ago had an episode of acute nerve pain into her L leg to the back of her knee. Her GP at the time had prescribed her gabapentin at increasing doses and after 8/52 her leg pain settled but she felt that her back pain had never returned to the level it was before this episode of nerve pain. She remained taking the gabapentin as her GP had told her that they would help her back but she felt somewhat down that her weight had steadily increased and she was now developing knee and lateral hip pain and was no longer able to enjoy walking which she had previously done.

The Ortho ICATS non-medical prescriber spent a long time explaining to the patient that her back pain was likely more mechanical in nature and with now generalised deconditioning. They explained that there was no evidence of any neural compromise and therefore she should stop taking her gabapentin as it is not proven to help low back and in fact may be contributing to her weight gain. A letter of recommendation was sent to the patient's GP to advise to reduce gradually reduce and eventually discontinue the prescription of gabapentin for the patient.

With the assistance of physiotherapy the patient was able to begin an exercise programme to improve her exercise tolerance, her ROM and her strength and then managed her general back pain with co-codamol PRN.

Patient 3

A 69 year old gentleman was referred to Ortho ICATS for further management of bilateral OA of knees. He had been slowly deteriorating in terms of level of mobility for a few years so had been prescribed naproxen 500mg BD with PPI cover, he had been taking this for at least 3 years.

On examination he presented with L worse than R moderate changes to medial knee and patella femoral joints. He had lost approximately 10 degrees of knee extension and flexion on each leg and had joint crepitus. He had no effusion to either knee. The pain he felt had worsened in the last 6/12 were he found it more difficult to do his ½ mile daily walk with his dog.

The patient was given a cortisone injection to both knees which improved his symptoms and allowed him to walk more freely. The Ortho ICATS non-medical

prescriber advised the patient that he should discontinue taking naproxen as long term anti-inflammatories can be harmful both in terms of his CV system and his stomach. He reported that he was having some difficulty controlling his BP but this was being put down to his reduced exercise capabilities. He was advised instead to replace the naproxen with simple analgesics which he could buy over the counter. A letter of recommendation was sent to his GP to advise stopping his naproxen prescription

Appendix 7: Patient satisfaction survey results

A patient satisfaction questionnaire was developed to obtain the views and experiences of patients who used during the pilot period. A service user questionnaire from a previous project was amended by the task and finish group to meet the needs of the pilot. Patients were provided with the satisfaction questionnaire at the end of their appointment and provided with a patient information leaflet to provide background information and further detail regarding the physiotherapist prescribing pilot. In addition, a freepost envelope to return the questionnaire was provided in order to maximise the number of There were 64 respondents in total.

Background

22 of the 64 (34%) respondents stated they were seen in the Southern Trust area; 11 of the 64 (17%) stated they were seen in the South Eastern Trust area. 31 respondents (48%) did not provide an answer to this question.

19 of the 64 (30%) responses were from Respiratory, 21 of the 64 (33%) were from Lymphoedema and 24 of the 64 (38%) did not provide a response to this question.

34 of the 64 (53%) respondents outlined that they were seen in an outpatient setting, 6 of the 64 (9%) were seen in a community setting and 24 (38%) respondents did not answer this question.

Process

60 out of the 63 (95%) respondents agreed that they were aware that the medication/garment was being prescribed/reviewed by a physiotherapist non-medical prescriber.

61 out of the 63 (97%) respondents agreed that it was explained clearly why the medication/garment was being prescribed.

Medication and garment information

43 of the 64 (67%) respondents completed the questions relating to medications. All 43 respondents (100%) agreed that they were advised on how to take the medication and how long to take the medication for. 42 out of the 43 respondents (98%) agreed that they were advised of possible risks or side effects and what to do should there be any reaction to the new medication being prescribed issued. 42 of the 43 (98%) respondents agreed that they were informed of arrangements for obtaining repeat prescriptions.

20 of the 64 (31%) respondents completed the questions relating to garments. All 20 respondents (100%) agreed that they were advised on how to correctly apply the garment and how long to wear the garment for. 19 out of the 20 respondents (95%) agreed that they were advised of possible risks or side effects and what to do should there be any reaction to the new garments being issued. 19 of the 20 (95%) respondents agreed that they were informed of arrangements for obtaining repeat prescriptions.

Satisfaction

60 of 62 (97%) respondents agreed that they were satisfied with the consultation and felt they received appropriate and sufficient information.

Patient perceived benefit

Each respondent was asked to identify how did the consultation benefitted them. Results are presented in main report.

Other ways that the consultation benefitted the patient

- I benefited from specialist experience knowledge with the medication
- Physio took time and patience to explain to my 87 year old dad and put his mind at ease
- One to one consultation was essential to measure for garment accurately
- It was the best treatment and advice I've had
- Wider knowledge base and more time given to explain all aspects of my condition
- Really excellent service, medications use and potential side effects really well explained. Avoided delays in receiving meds, able to start that day
- Very helpful overall
- It was much easier - the physio prescribing, meds, saving time waiting on doctors appointments
- Told physios my left ankle was giving me pain - ended up on exercise - fluid on LF was more when using stocking. Stopped using it
- Less steps in process for prescription to supply so less chance for errors and non-prescription of correct number of garments between GP, community pharmacist and delivery as with old system
- I felt the physio was more specialised in the area - previously the GP had just ratified the decision
- A fantastic service

17 of the 64 (27%) respondents agreed that if there were no medications/garments prescribed, but there were changes to their existing medications/garments, they were aware of future planned changes. 30 of the 64 (47%) stated this was not applicable and 17 of the 64 (27%) did not answer this question.

Suggestions for improvement

23 of the 64 (35%) respondents included comments on how the service could be improved upon, these are included in the box below:

Comments on how the service could be improved upon:

- No, I was very happy with my consultation and was given advice on how best to deal with my condition and not to hesitate contacting them
- Waiting for garment to go through my GP then pharmacy took far too long and really the garment is an immediate need as size of arm was changeable and arm was painful
- Perfectly well managed service
- I can't see how service could be improved. I received excellent care and everything was explained very well
- The service was brilliant
- Excellent!
- I was seen by Wesley today at Ulster hospital, ward 22. He was so friendly and helpful; I was at ease during my appointment. He was so professional explaining everything as we went along. Sometimes when seeing a doctor, they don't explain things. He was a marvellous, a real asset to the NHS. Thank you!
- No. Service was very good. Very professional and helpful
- More staff would be beneficial
- To be seen more with the doctor
- This service might be more widely used if it was provided more locally, perhaps at a hospital with more parking
- Excellent service
- My consultant Stuart was amazing!
- No, service was excellent; provided me with positive outlook and hope for my future health and wellbeing. Thank you
- Better to see patient rather than telephone call
- This is an excellent service. Non-medical prescribing by respiratory hub.
- No. excellent service
- Please keep this service going!
- waste of time
- Less time spent between GP, community pharmacist and supplier, checking if order correct, correcting errors and delivery shorter. Also when query with

order only 1 person to contact to sort rather than back and forth between the 3.

- A great time saver
- A very positive service. It seems much more logical for the specialist to prescribe specialist items. A GP is not a specialist and does not have training in this area. However, further funding would be required to ensure staff do not become overwhelmed by additional roles and responsibilities
- No - it is just brilliant! It saves so much time, confusion and complication and makes for a much smoother, efficient and easy service with no delay. Absolute game changer
- No, I was very satisfied

Appendix 8: Items prescribed between Nov 21 and Jun 22

Drug	Therapeutic group
Doxycycline 100mg capsules	Antibiotic
Furosemide 40mg tablets	Diuretic
Prednisolone 5mg tablets	Oral steroid
Varenicline 1mg tablets and Varenicline 500microgram tablets	Varenicline
Aerobika mucus clearance device	mucus clearing device
AeroChamber Plus	Spacer
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Fostair 100micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Nicorette invisi 25mg/16hours patches	NRT
Trelegy Ellipta 92micrograms/dose / 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Compression hosiery class I below knee stocking circular knit standard stock size	LO garment
Jobst Elvarex custom fit class 1 (18-21mmHg) below knee lymphoedema garment	LO garment
Jobst Elvarex non-standard colour for lymphoedema garment lower extremities	LO garment
Jobst Elvarex Soft closed toe for lymphoedema garment	LO garment
Jobst Elvarex Soft SoftFit for lymphoedema garment lower extremities	LO garment
Jobst Opaque class 1 (18-21mmHg) tights closed toe lymphoedema garment regular size VI	LO garment
Mometasone 50micrograms/dose nasal spray	Nasal spray
Prednisolone 5mg tablets	Oral steroid
AeroChamber Plus	Spacer
Relvar Ellipta 184micrograms/dose / 22micrograms/dose dry powder inhaler	inhaler device
Serc 16mg tablets	Oral antihistamine
Symbicort 200/6 Turbohaler	Inhaler device
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Amoxicillin 500mg capsules	Antibiotic
Esomeprazole 20mg gastro-resistant tablets	PPI
Montelukast 10mg tablets	LTRA
Omeprazole 20mg gastro-resistant capsules	PPI
Omeprazole 20mg gastro-resistant tablets	PPI
Prednisolone 5mg tablets	Oral steroid
Salbutamol 100micrograms/dose inhaler CFC free	Inhaler device
Varenicline 1mg tablets and Varenicline 500microgram tablets	Varenicline

Acapella mucus clearance device	mucus clearing device
AeroChamber Plus	Spacer
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Avamys 27.5micrograms/dose nasal spray	Nasal spray
Dymista 137micrograms/dose / 50micrograms/dose nasal spray	Nasal spray
Fostair 100micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Fostair 200micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Nicorette 15mg Inhalator	NRT
Nicorette invisi 15mg/16hours patches	NRT
Spiriva Respimat 2.5micrograms/dose solution for inhalation cartridge with device	Inhaler device
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Ciprofloxacin 750mg tablets	Antibiotic
Doxycycline 100mg capsules	Antibiotic
Omeprazole 20mg gastro-resistant capsules	PPI
Salbutamol 100micrograms/dose inhaler CFC free	Inhaler device
Salbutamol 2.5mg/2.5ml nebuliser liquid unit dose vials	Nebules
Sodium chloride 0.9% nebuliser liquid 2.5ml unit dose ampoules	Saline
AeroChamber Plus	Spacer
Colomycin 2million unit powder for solution for injection vials	Colomycin
Dymista 137micrograms/dose / 50micrograms/dose nasal spray	Nasal spray
Eklira 322micrograms/dose Genuair	Inhaler device
Nicorette Cools 2mg lozenges	NRT
Mometasone 50micrograms/dose nasal spray	Nasal spray
Montelukast 10mg tablets	LTRA
AeroChamber Plus	Spacer
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Incruse Ellipta 55micrograms/dose dry powder inhaler	Inhaler device
Prednisolone 5mg tablets	Oral steroid
Salbutamol 100micrograms/dose inhaler CFC free	Inhaler device
AeroChamber Plus	Spacer
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Avamys 27.5micrograms/dose nasal spray	Nasal spray
Flutiform 125micrograms/dose / 5micrograms/dose inhaler	Inhaler device

Fostair 100micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Incruse Ellipta 55micrograms/dose dry powder inhaler	Inhaler device
Nebusal 7% inhalation solution 4ml vials	Saline
Nicorette 15mg Inhalator	NRT
Spiriva Respimat 2.5micrograms/dose solution for inhalation cartridge with device	Inhaler device
Symbicort 400/12 Turbohaler	Inhaler device
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Coban 2 Comfort Foam Layer bandage 10cm x 3.5m	bandage
Coban 2 multi-layer compression bandage kit 5cm x 2.7m	LO garment
Haddenham EasyWrap Light (20-30mmHg) foot lymphoedema garment regular small	LO garment
Haddenham EasyWrap Light (20-30mmHg) leg lymphoedema garment regular small	LO garment
Haddenham Star Cotton class 2 (23-32mmHg) tights closed toe lymphoedema garment extra wide short size VII	LO garment
Jobst Opaque class 1 (18-21mmHg) thigh length closed toe with dotted silicone band lymphoedema garment standard petite size I	LO garment
Jobst Opaque class 2 (23-32mmHg) thigh length closed toe with dotted silicone band lymphoedema garment standard petite size I	LO garment
Jobst UlcerCARE compression liner pack XX large	LO garment
Jobst UltraSheer class 2 (23-32mmHg) below knee closed toe lymphoedema garment petite size IV	LO garment
Mepitel dressing 8cm x 10cm	dressing
Mesorb dressing 10cm x 10cm	dressing
ReadyWrap calf wrap medium	LO garment
ReadyWrap foot wrap medium right	LO garment
Co-amoxiclav 500mg/125mg tablets	Antibiotic
Mometasone 50micrograms/dose nasal spray	Nasal spray
Prednisolone 5mg tablets	Oral steroid
Varenicline 1mg tablets and Varenicline 500microgram tablets	Varenicline
AeroChamber Plus	Spacer
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Fostair 200micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Fostair NEXThaler 200micrograms/dose / 6micrograms/dose dry powder inhaler	Inhaler device
Relvar Ellipta 184micrograms/dose / 22micrograms/dose dry powder inhaler	inhaler device
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Ipratropium bromide 250micrograms/1ml nebuliser liquid unit dose vials	Nebules
Omeprazole 20mg gastro-resistant capsules	PPI
Omeprazole 20mg gastro-resistant tablets	PPI

Salbutamol 100micrograms/dose inhaler CFC free	Inhaler device
Acapella mucus clearance device	mucus clearing device
AeroChamber Plus	Spacer
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Avamys 27.5micrograms/dose nasal spray	Nasal spray
Clenil Modulite 100micrograms/dose inhaler	Inhaler device
Dymista 137micrograms/dose / 50micrograms/dose nasal spray	Nasal spray
Fostair 200micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Salamol 100micrograms/dose inhaler CFC free	Inhaler device
Spiriva Respimat 2.5micrograms/dose solution for inhalation cartridge with device	Inhaler device
Symbicort 400/12 Turbohaler	Inhaler device
Trelegy Ellipta 92micrograms/dose / 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Ipratropium bromide 250micrograms/1ml nebuliser liquid unit dose vials	Nebules
Salbutamol 2.5mg/2.5ml nebuliser liquid unit dose vials	Nebules
Salbutamol 2.5mg/2.5ml nebuliser liquid unit dose vials	Nebules
Aerobika mucus clearance device	mucus clearing device
AeroChamber Plus	Spacer
Colomycin 2million unit powder for solution for injection vials	Colomycin
Nebusal 7% inhalation solution 4ml vials	Saline
Amoxicillin 500mg capsules	Antibiotic
Cetirizine 10mg tablets	Oral antihistamine
Mometasone 50micrograms/dose nasal spray	Nasal spray
Montelukast 10mg tablets	LTRA
Omeprazole 10mg gastro-resistant tablets	PPI
Omeprazole 20mg gastro-resistant capsules	PPI
Pantoprazole 40mg gastro-resistant tablets	PPI
Prednisolone 5mg tablets	Oral steroid
AeroChamber Plus	Spacer
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Dymista 137micrograms/dose / 50micrograms/dose nasal spray	Nasal spray
Flutiform 250micrograms/dose / 10micrograms/dose inhaler	Inhaler device

Fostair 100micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Fostair 200micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Nystan 100,000units/ml oral suspension (ready mixed)	Antifungal
Salamol 100micrograms/dose inhaler CFC free	Inhaler device
Spiriva Respimat 2.5micrograms/dose solution for inhalation cartridge with device	Inhaler device
Symbicort 100/6 Turbohaler	Inhaler device
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Carbocisteine 375mg capsules	Carbocisteine
Cetirizine 10mg tablets	Oral antihistamine
Ciprofloxacin 750mg tablets	Antibiotic
Lansoprazole 15mg gastro-resistant capsules	PPI
Montelukast 10mg tablets	LTRA
Omeprazole 20mg gastro-resistant capsules	PPI
Omeprazole 20mg gastro-resistant tablets	PPI
Prednisolone 5mg tablets	Oral steroid
Salbutamol 100micrograms/dose inhaler CFC free	Inhaler device
Acapella mucus clearance device	mucus clearing device
AeroChamber Plus	Spacer
AeroChamber Plus Flow-Vu Anti-Static with adult large mask	Spacer
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Avamys 27.5micrograms/dose nasal spray	Nasal spray
Dymista 137micrograms/dose / 50micrograms/dose nasal spray	Nasal spray
Nicorette 15mg Inhalator	NRT
Nicorette invisi 15mg/16hours patches	NRT
Spiriva 18microgram inhalation powder capsules with HandiHaler	Inhaler device
Spiriva Respimat 2.5micrograms/dose solution for inhalation cartridge with device	Inhaler device
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Amoxicillin 500mg capsules	Antibiotic
Salamol 100micrograms/dose Easi-Breathe inhaler	Inhaler device
Clenil Modulite 100micrograms/dose inhaler	Inhaler device
Fostair 100micrograms/dose / 6micrograms/dose inhaler	Inhaler device

Relvar Ellipta 184micrograms/dose / 22micrograms/dose dry powder inhaler	inhaler device
Trelegy Ellipta 92micrograms/dose / 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Doxycycline 100mg capsules	Antibiotic
Varenicline 1mg tablets and Varenicline 500microgram tablets	Varenicline
AeroChamber Plus with adult mask	Spacer
Nicorette 15mg Inhalator	NRT
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Omeprazole 20mg gastro-resistant tablets	PPI
Prednisolone 5mg tablets	Oral steroid
Salbutamol 100micrograms/dose inhaler CFC free	Inhaler device
AeroChamber Plus	Spacer
AeroChamber Plus with adult mask	Spacer
Aquacel Ag Extra dressing 5cm x 5cm square	dressing
Aquacel Ag Ribbon dressing 1cm x 45cm	dressing
Avamys 27.5micrograms/dose nasal spray	Nasal spray
Dressit sterile dressing pack with medium/large gloves	dressing
Dymista 137micrograms/dose / 50micrograms/dose nasal spray	Nasal spray
Fostair 100micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Fostair 200micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Incruse Ellipta 55micrograms/dose dry powder inhaler	Inhaler device
Relvar Ellipta 184micrograms/dose / 22micrograms/dose dry powder inhaler	inhaler device
Trelegy Ellipta 92micrograms/dose / 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Tubigrip bandage 10cm size F	bandage
Tubigrip bandage 6.75cm size C	bandage
Tubigrip bandage 7.5cm size D	bandage
Carbocisteine 375mg capsules	Carbocistein e
Esomeprazole 20mg gastro-resistant tablets	PPI
Montelukast 10mg tablets	LTRA
Omeprazole 20mg gastro-resistant capsules	PPI
Omeprazole 20mg gastro-resistant tablets	PPI
Prednisolone 5mg tablets	Oral steroid
Salbutamol 100micrograms/dose inhaler CFC free	Inhaler device
Varenicline 1mg tablets and Varenicline 500microgram tablets	Varenicline

Acapella mucus clearance device	mucus clearing device
AeroChamber Plus	Spacer
AeroChamber Plus with adult mask	Spacer
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Avamys 27.5micrograms/dose nasal spray	Nasal spray
Dymista 137micrograms/dose / 50micrograms/dose nasal spray	Nasal spray
Flutiform 125micrograms/dose / 5micrograms/dose inhaler	Inhaler device
Flutiform 250micrograms/dose / 10micrograms/dose inhaler	Inhaler device
Fostair 100micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Fostair 200micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Spiriva Respimat 2.5micrograms/dose solution for inhalation cartridge with device	Inhaler device
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Volumatic	Spacer
DebriSoft pad 10cm x 10cm	LO garment
Juzo Easy Fit XL compression hosiery applicator	LO garment
Salbutamol 100micrograms/dose inhaler CFC free	Inhaler device
AeroChamber Plus	Spacer
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Mometasone 50micrograms/dose nasal spray	Nasal spray
AeroChamber Plus	Spacer
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Omeprazole 20mg gastro-resistant capsules	PPI
Acapella mucus clearance device	mucus clearing device
Avamys 27.5micrograms/dose nasal spray	Nasal spray
Clenil Modulite 100micrograms/dose inhaler	Inhaler device
Flutiform 125micrograms/dose / 5micrograms/dose inhaler	Inhaler device
Fostair 200micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Spiriva Respimat 2.5micrograms/dose solution for inhalation cartridge with device	Inhaler device
Clenil Modulite 100micrograms/dose inhaler	Inhaler device
Qvar 50micrograms/dose Easi-Breathe inhaler	Inhaler device

Relvar Ellipta 184micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Symbicort 100/6 Turbohaler	Inhaler device
Trelegy Ellipta 92micrograms/dose / 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Carbocisteine 375mg capsules	Carbocisteine
AeroChamber Plus	Spacer
Dymista 137micrograms/dose / 50micrograms/dose nasal spray	Nasal spray
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Amoxicillin 500mg capsules	Antibiotic
Doxycycline 100mg capsules	Antibiotic
Fluticasone 125micrograms/dose / Salmeterol 25micrograms/dose inhaler CFC free	Inhaler device
Mometasone 50micrograms/dose nasal spray	Nasal spray
Prednisolone 5mg tablets	Oral steroid
Salbutamol 100micrograms/dose inhaler CFC free	Inhaler device
Aerobika mucus clearance device	mucus clearing device
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Clenil Modulite 100micrograms/dose inhaler	Inhaler device
Fostair 100micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Fostair 200micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Spiriva Respimat 2.5micrograms/dose solution for inhalation cartridge with device	Inhaler device
Carbocisteine 375mg capsules	Carbocisteine
Mometasone 50micrograms/dose nasal spray	Nasal spray
Montelukast 10mg tablets	LTRA
Omeprazole 20mg gastro-resistant tablets	PPI
Prednisolone 5mg tablets	Oral steroid
Salbutamol 100micrograms/dose inhaler CFC free	Inhaler device
Acapella mucus clearance device	mucus clearing device
AeroChamber Plus	Spacer
AeroChamber Plus with adult mask	Spacer
AeroChamber Plus with infant mask	Spacer
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Avamys 27.5micrograms/dose nasal spray	Nasal spray

Dymista 137micrograms/dose / 50micrograms/dose nasal spray	Nasal spray
Flutiform 125micrograms/dose / 5micrograms/dose inhaler	Inhaler device
Flutiform 250micrograms/dose / 10micrograms/dose inhaler	Inhaler device
Fostair 100micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Fostair 200micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Nicorette 15mg Inhalator	NRT
Nicorette invisi 15mg/16hours patches	NRT
Nicorette invisi 25mg/16hours patches	NRT
Spiriva Respimat 2.5micrograms/dose solution for inhalation cartridge with device	Inhaler device
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Trelegy Ellipta 92micrograms/dose / 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Carbocisteine 375mg capsules	Carbocistein e
Salbutamol 100micrograms/dose inhaler CFC free	Inhaler device
AeroChamber Plus with adult mask	Spacer
Cetraben lotion	Topical
Coban 2 Comfort Foam Layer bandage 10cm x 3.5m	bandage
Coban 2 Comfort Foam Layer bandage 5cm x 1.2m	bandage
Coban 2 Compression Layer bandage 10cm x 4.5m	LO garment
Coban 2 Compression Layer bandage 5cm x 2.7m	LO garment
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Flutiform 250micrograms/dose / 10micrograms/dose inhaler	Inhaler device
Co-amoxiclav 500mg/125mg tablets	Antibiotic
Aerobika mucus clearance device	mucus clearing device
Incruse Ellipta 55micrograms/dose dry powder inhaler	Inhaler device
Relvar Ellipta 184micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Jobst FarrowWrap (30-40mmHg) strong footpiece lymphoedema garment regular small	LO garment
Jobst FarrowWrap (30-40mmHg) strong legpiece lymphoedema garment regular large	LO garment
Juzo Dynamic class 2 (23-32mmHg) thigh length closed toe with silicone top band lymphoedema garment short size V	LO garment
ReadyWrap knee wrap extra large	LO garment
Amoxicillin 500mg capsules	Antibiotic
Ciprofloxacin 500mg tablets	Antibiotic

Omeprazole 20mg gastro-resistant capsules	PPI
Prednisolone 5mg tablets	Oral steroid
Salbutamol 100micrograms/dose inhaler CFC free	Inhaler device
Tiotropium bromide 2.5micrograms/dose inhalation solution cartridge CFC free	Inhaler device
AeroChamber Plus	Spacer
DermaSilk briefs 7-10 years boy	coding error?
Fostair 200micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Relvar Ellipta 184micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Carbocisteine 375mg capsules	Carbocisteine
Mometasone 50micrograms/dose nasal spray	Nasal spray
Omeprazole 20mg gastro-resistant tablets	PPI
Prednisolone 5mg tablets	Oral steroid
Salbutamol 100micrograms/dose inhaler CFC free	Inhaler device
Acapella mucus clearance device	mucus clearing device
AeroChamber Plus	Spacer
AeroChamber Plus with adult mask	Spacer
Anoro Ellipta 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Avamys 27.5micrograms/dose nasal spray	Nasal spray
Clenil Modulite 100micrograms/dose inhaler	Inhaler device
Fostair 100micrograms/dose / 6micrograms/dose inhaler	Inhaler device
Nicorette 15mg Inhalator	NRT
Nicorette invisi 15mg/16hours patches	NRT
Nicorette invisi 25mg/16hours patches	NRT
Salamol 100micrograms/dose inhaler CFC free	Inhaler device
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Hand Priced Uncoded Item	Unknown
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Co-amoxiclav 500mg/125mg tablets	Antibiotic
Doxycycline 100mg capsules	Antibiotic
Hand Priced Uncoded Item	Unknown
Nystatin 100,000units/ml oral suspension	Antifungal
Prednisolone 5mg tablets	Oral steroid

Salbutamol 2.5mg/2.5ml nebuliser liquid unit dose vials	Nebules
Sodium chloride 0.9% nebuliser liquid 2.5ml unit dose ampoules	Saline
AeroChamber Plus with adult mask	Spacer
Trelegy Ellipta 92micrograms/dose / 55micrograms/dose / 22micrograms/dose dry powder inhaler	Inhaler device
Trimbow 87micrograms/dose / 5micrograms/dose / 9micrograms/dose inhaler	Inhaler device
Sodium chloride 0.9% nebuliser liquid 2.5ml unit dose ampoules	Saline
Cetraben cream	Topical