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

Prepared by

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Summary of Consultation Responses to Proposals to Introduce Independent Prescribing by Podiatrists

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Contents

Executive Summary

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

Podiatry
Podiatry is a graduate profession specialising in the diagnosis and management of a range of pathological conditions, involving the medical, surgical, mechanical, physical and adjunctive treatment of disorders, injuries and defects of the foot. For example; musculoskeletal, diabetes foot care, dermatology, rheumatology and surgical management.

Background to the Consultation

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

Public Consultation
The public consultation on proposals took place between 15th September and 30th December 2011. The UK-wide consultation was issued jointly by DH and the MHRA and was published on the Department of Health website and consultation hub with a link on the MHRA website. Respondents were able to submit their feedback via an online portal, by email or in hard copy. The podiatrist consultation received 1210 responses in total. Of those 556 responses were received via the online portal (Citizen Space), 539 responses were received by email and 115 responses were received in hard copy.

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

Summary of responses to the consultation

- **Independent prescribing**

  Of the 1210 responses received in total 99% (1203) of all respondents including organisations and individuals supported one of the options for extending independent prescribing by podiatrists. Of those:

  - Option 1 - 77% (62) of organisations and 84% of individuals supported extending independent prescribing by podiatrists from a full formulary for any condition
  - Option 2 - 19% (15) of organisations and 8% (87) of individuals supported extending independent prescribing by podiatrists from a specified formulary/specified conditions
  - Option 3 & 4 – 1% (1) and 2% (2) of organisations and 3% (36) and 4% (48) of individuals supported extending independent prescribing by podiatrists from either a specified formulary for any condition or for specified conditions from a full formulary
  - 1% (7) of respondents including 1 organisation and 6 individuals supported no change

- **Controlled drugs**

  - 80% (65) of organisations and 93% (1052) of individuals selected ‘Yes’ to the limited list of controlled drugs
  - 4% (3) of organisations and 3% (30) of individuals selected ‘No’
  - 11% (9) of organisations and 2% (24) of individuals selected ‘Partly’ and 5% (4) of organisations and 2% (23) of individuals selected ‘Neither agree nor disagree’

- **Mixing of medicines**

  - 84% (68) of organisations and 90% (1019) of individuals selected ‘Yes’ to the mixing of medicines
  - 5% (4) of organisations and 4% (40) of individuals selected ‘No’
  - 6% (5) of organisations and 1% (8) of individuals selected ‘partly’ 5% (4) of organisations and 5% (62) of individuals selected ‘Neither agree nor disagree’.

Next Steps

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

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

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

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

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

Background

Podiatry

Podiatry is a graduate profession specialising in the diagnosis and management of a range of pathological conditions, involving the medical, surgical, mechanical, physical and adjunctive treatment of disorders, injuries and defects of the foot. For example; musculoskeletal, diabetes foot care, dermatology, rheumatology and surgical management.

Podiatrists currently use medicines through Patient Group Directions (PGDs), Patient Specific Directions (PSDs), Exemptions and, since 2005, Supplementary Prescribing.

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

It was proposed that Independent Prescribing would enable podiatrists to close this gap in the current care pathway for patients presenting with acute problems, and in particular provide better access to services for patients in the community, those with access issues and for marginalised or transient groups such as travellers, migrant workers, homeless people, students and offenders.

Summary of regulation and governance

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

The professional bodies for podiatrists, **The Society of Chiropodists and Podiatrists** and **The Institute of Chiropodists and Podiatrists**, provide ethical standards and define the scope of practice for members, 'Good Practice Guidance'[3] and support for professional development.

Podiatrist prescribing competency standards are defined by the **National Prescribing Centre's** 'Single Competency Framework for All Prescribers', (May 2012)[4].

The competency standards will be mapped to the draft 'Outline Curricula Frameworks for Independent Prescribing Programmes', which will be maintained by the **Allied Health Professions Federation (AHPF)**[5] from August 2012 and hosted on an AHP professional body website to ensure podiatrist's prescribing competency is consistent with all other prescribers. The AHPF provides collective leadership and representation on common issues that impact upon the 12 Allied Health Professions.

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

[3] To be published on the respective professional body websites prior to commencement of prescribing responsibilities.
[4] http://www.npc.co.uk/improving_safety/improving_quality/resources/single_comp_framework.pdf
[5] http://www.ahpf.org.uk/
[6] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/healthcare/medicinespharmacyandindustry/prescriptions/thenon-medicalprescribingprogramme/index.htm

The **National Prescribing Centre**[7] produces policies for Medicines Management governance, for the management of prescribers within organisations. They also produce guidance on 'Mixing of Medicines Prior to Administration in Clinical Practice' and 'Safer Management of Controlled Drugs' for primary and secondary care.

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

Background to the Consultation: Scoping Study and Engagement Exercise

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

In 2009 an Allied Health Professions (AHPs) Prescribing and Medicines Supply Mechanisms Scoping Project[9] was undertaken to establish whether there was evidence of service and patient need to support extending prescribing and medicines supply mechanisms available to AHPs. The project found a strong case for extending independent prescribing to physiotherapists and podiatrists and a project was established to take the work forward.

Following recommendation of the Medicines and Healthcare products Regulatory Agency (MHRA) an engagement exercise was undertaken in autumn 2010. The engagement exercise for podiatrists gathered information on the key issues in respect of independent prescribing by podiatrists from a range of key stakeholders including; professional bodies, Royal Colleges, individual practitioners and the public.

The response to the two engagement exercises was as follows:

- 388 (177 for podiatrists) responses received in total
  - 17% from organisations
  - 83% from individuals
- 91% of the total responses supported one of the options for independent prescribing by podiatrists and physiotherapists
- 2% of the total responses were in favour of no change
- 7% of the total responses were undecided or not selecting a preference

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

The Department of Health for England with support from the Medicines and Healthcare products Regulatory Agency agreed to take forward the public consultations on independent prescribing by podiatrists, to improve patients health as part of the policy

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

developments to make better use of clinicians' skills and to make it easier for patients to get access to the medicines that they need.

Independent Prescribing may enable new roles and new ways of working to improve the quality of services – delivering safe, effective services focussed on the patient experience. It can facilitate partnership working across professional and organisational boundaries within commissioning/provider landscapes and with patients to redesign care pathways that are cost-effective and sustainable, e.g. improving the transition from acute to community care. It may also enhance choice and competition, maximising the benefits for patients and the taxpayer.

Consultation Process

General

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

Communications

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

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

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

Methods

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

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

Consultation Questions

Respondents to the consultation were required to give their name as well as a response to three main consultation questions. The three mandatory questions were:

Question 1. Which is your preferred option for introducing independent prescribing[10] by podiatrists

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

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

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

Question 3. Do you agree with making amendments to medicines legislation to allow podiatrists who are independent prescribers to mix medicines prior to administration or direct others to mix?

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

Additional information regarding the proposals was requested via the following five questions:

Question 4. Do you have any additional information on any aspects NOT already considered that could prevent the proposal for independent prescribing going forward?

Question 5. Do you have any additional information on any aspects NOT already considered that could support the proposal for independent prescribing going forward?

Question 6. Does the consultation draft Impact Assessment document give an accurate indication of the likely costs and benefits of the proposal?

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

Question 7. Can you offer any additional information to the consultation stage Equality Analysis document on how these proposals may impact either positively or negatively on specific equality characteristics, particularly concerning; disability, ethnicity, gender, sexual orientation, age, religion or belief, and human rights?

Question 8. Can you offer any additional information on how these proposals may impact either positively or negatively on any specific groups e.g. students, travellers, immigrants, children, offenders?

Consultation Responses

The consultation received 1,210 responses in total. Respondents were able to submit their feedback via an online portal (Citizen Space), by email or in hard copy. 556 responses were received via the online portal (Citizen Space), 539 responses were received by email and 115 responses were received in hard copy.

The consultation received 912 responses from England, 90 from Scotland, 57 from Wales and 15 from Northern Ireland, 120 respondents did not indicate which country they were responding from and 16 responses were from either British or UK-wide organisations. Individual responses were also received from Trinidad, Hong Kong, USA, Cyprus, Costa Rica and Ireland.

The consultation received 81 responses on behalf of organisations and 1129 responses from individuals including doctors, pharmacists, nurses, podiatrists, patients, carers and members of the public.

There were 180 responses from patients, carers or members of the public and 862 responded as a health or social care professional including; doctors, nurses, pharmacists, and Allied Health Professionals and 81 responded on behalf of an organisation.

Appendix C provides some general statistical information on respondents.

Responses were categorised into four organisational groups and group 5 included responses from individuals. Appendix D includes responses to questions 1, 2, and 3 from all organisations.

Table 1: Groups by type:

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

There were five options for respondents to select in regard to question 1.

Table 2: Question 1 Options

Option 1.	Independent prescribing for any condition from a full formulary (BNF).
Option 2.	Independent prescribing for specified conditions from a specified formulary.
Option 3.	Independent prescribing for any condition from a specified formulary.
Option 4.	Independent prescribing for specified conditions from a full formulary.
Option 5.	No change (i.e. no change to the prescribing rights of podiatrists)

Summary of Responses by Question

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

Table 3: Question 1

	Organisations										Individ's			
	Group 1		Group 2		Group 3		Group 4		All Orgs		Group 5		Total	
Option	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
Option 1	8	57%	14	93%	5	83%	35	76%	62	77%	952	84%	1,014	84%
Option 2	6	43%	1	7%	0	0%	8	17%	15	19%	87	8%	102	8%
Option 3	0	0%	0	0%	1	17%	0	0%	1	1%	36	3%	37	3%
Option 4	0	0%	0	0%	0	0%	2	4%	2	2%	48	4%	50	4%
Option 5	0	0%	0	0%	0	0%	1	2%	1	1%	6	1%	7	1%
Total:	14		15		6		46		81		1129		1,210	

Option 1 was the preferred option for the majority of service provider organisations, educational organisations, Allied Heath Professional bodies, health and social care professionals, patients and the public. Respondents representing professional regulators and professional representative bodies including the **Royal Pharmaceutical Society** (RPS), the **Nursing and Midwifery Council** (NMC), the **Care Quality Commission** (CQC) and the **Health Professions Council** (HPC) also supported this option.

Comments in support of option 1 referred to the impracticalities of a 'Specified Formulary'.

> *We support the proposal for appropriately trained podiatrists to be able to prescribe independently any medicine for any condition within their competence. We agree that specified formularies would quickly become out of date and would be difficult to administer.* ***RPS***
>
> *Nurse prescribing changed from a limited formulary to independent prescribing. A report of the evaluation of the effectiveness shows this to be the most effective mechanism, and minimises confusion about who may prescribe what and the need for regular updating of formularies to support best practice. Option one creates clear lines of professional responsibility and accountability.* ***NMC***
>
> *Specified formulae are too limiting and given appropriate instruction and relevant examination Podiatrists should be able to prescribe independently and safely and effectively as do Nurse Practitioners.* ***Doctor***

Comments in support of option 1 noted the impracticality of a limited list of conditions for podiatry.

> *In particular podiatry spans a wide range of specialist areas in addition to Rheumatology, thus it would be difficult for any list of conditions to be comprehensive and cover this range. If access to medicines or treatment regimens are limited, this would need constant review to ensure current best practice is reflected in the legislation.* ***British Health Professionals in Rheumatology***

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

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

> *Allowing trained podiatrists access to a full formulary would be in line with recent changes in the regulations surrounding nurse prescribing and this has been demonstrated to be the most effective method for safe prescribing.* ***British Health Professionals in Rheumatology***

> *Any restriction placed on podiatrist prescribing should be at the discretion of the employing organisation, as is the case for nurse and pharmacist independent prescribers. Any legislative restriction may result in further impediments to good practice and delays in patients accessing medicines as there are under existing supplementary prescribing processes.* ***University Hospital of South Manchester NHS Foundation Trust***

Other comments refer to the flexibility Option 1 offers professionals but stress that this flexibility is within the practitioner's scope of practice and competence.

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

> *The regulatory and governance processes already in place for podiatrist prescribers require that they only prescribe within their scope and practice and clinical speciality. It therefore seems reasonable that their prescribing practice continues to be regulated through professional regulatory standards, and not restricted by a limited formulary, or conditions. By introducing Option one, podiatrists will be able to make full use of their skills and expertise.* ***NMC***

Chiropodists/podiatrist and physiotherapist independent prescribers would have to meet the same requirements as our other registrants. They would only be able to practice where they have the knowledge and skills to do so safely and effectively. In addition, they would have to refer to other professionals where appropriate. This would mean that they would only be able to prescribe medication where they had the knowledge and skills to be able to do so safely and effectively. ***HPC***

When a patient is referred or independently seeks the assistance of a podiatrist, it is important that the podiatrist can treat that patient effectively and should therefore be able to treat any condition relating to the feet with a full formulary. ***Pharmacist***

A responsible clinician will only prescribe appropriate medicines for appropriate conditions in the interest of patient care and with patient safety paramount. ***Podiatrist***

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

This will enable new roles and new ways of working to improve quality of services focused on patient experience and is also shown in the impact assessment to provide the greatest financial saving. ***Royal Society for Public Health***

Option 1 will ensure and enhance responsiveness to patient need, widen patient choice, and enhance accessibility to medicines in terms of location as well as provider. It will also further support role flexibility and workforce redesign, ensuring better use of GP time and more collaborative inter-professional working. ***Allied Health Professions Federation***

The spectrum of patients and conditions dealt with by podiatrists makes option 1 the most appropriate option, and particularly important for patients with diabetes where no delay in receiving treatment for diabetes related foot conditions is vital to achieving the best outcomes and enabling such patients to remain healthy, mobile and independent. ***Allied Health Professions - Professional Advisory Board***

Option 1 provides good opportunities to ensure and enhance responsiveness to patient need, widen patient choice, and enhance accessibility to medicines in terms of location as well as provider. It will also further support role flexibility and workforce redesign, ensuring better use of GP time and more collaborative inter-professional working. In addition, there is evidence to suggest that independent prescribing by nurses and pharmacists is operating safely and patients are satisfied (Latter et al, 2010; http://eprints.soton.ac.uk/184777/) ***Health, Ethics and Law network, University of Southampton***

*Podiatrists are highly trained practitioners and prescribing with additional training should be within their competence and could greatly enhance patient care. Current delays in podiatric treatment/deterioration due to delays in prescribing by medical practitioners who often have not even seen the patient and are relying on information from the podiatrist are unacceptable and compromise patient care. These delays could be alleviated if podiatrists became independent prescribers with additional training. I work closely with independent nurse prescribers within a hospital setting in acute medicine and the benefits are enormous**. Doctor***

It seems clear to me as a patient, that provided all the competencies checks and balances are in place and that there is good communication with the GP and along any patient pathway then any opportunity to improve or modernise service(s) can only be positive and possibly improve patient outcomes and their independence and quality of life. ***Patient***

I went to the doctors because i was advised by the podiatrist to ask for medication for my nails as they are not allowed to prescribe. I had to explain to my doctor what it was for I felt that i wasted his time for something that could have been done at the clinic. ***Patient***

Option 2: Independent prescribing for specified conditions from a specified formulary

Option 2 was generally supported by several medical organisations including the **British Medical Association** (BMA), the **Royal College of General Practitioners** (RCGP), the **Royal College of GPs Wales**, the **Royal College of Surgeons**. The themes that emerged from comments reflected the need for podiatrists to work within their scope of practice and competence, prescribe medicines from a limited formulary relevant to their practice and provide good communication of their prescribing to GPs and other relevant clinicians.

Option 2.We can see the advantages of allowing physiotherapists and podiatrists to prescribe drugs for specific conditions related to musculoskeletal problems. However, as mentioned above, we would strongly emphasise the importance of communication with GPs about prescribing decisions made so that the GP record can be kept up to date to avoid adverse incidents. ***Royal College of General Practitioners***

In order to realise some of the patient benefits outlined in the document whilst ensuring patient safety, we would support independent prescribing under specified conditions from a specified formulary (option 2). We believe that prescribing rights specifically in the areas of anaesthetics, antibiotics and analgesics should not be extended further than current regulations allow. In these areas, input from a doctor is often required to take into account the complete medical history of the patient in order to

assess for example the potential for drug interactions with medication prescribed for co-morbidities. ***Royal College of Surgeons***

The BMA is open to the idea of extending prescribing rights to appropriately qualified and experienced healthcare professionals to improve the safety, effectiveness, patient experience and productivity of healthcare. Therefore, we believe that healthcare professionals who are not doctors, such as podiatrists, should only be permitted to prescribe from a limited range of drugs as is the case for dentists. ***BMA***

Option 1 has the maximum flexibility but raises concerns that the podiatrist may stray into areas of higher risk for the patient by diagnosing and prescribing for conditions outside their experience or training. There is also the risk of new prescribers over-treating conditions that may get better untreated. Option 2 would seem to give sufficient flexibility to use the skills of the podiatrist without the risks but there is the issue of keeping the list up to date. Overall, Option 2 is safer for new independent prescribers (as happens in hospitals for newly-qualified doctors). The position could be reviewed at a later date as independent prescribers become more experienced. Any prescriber must ensure that primary care is fully informed so that any interactions can be avoided and side effects recognised. It is good practice to draw up a list of what they feel competent to prescribe and for any prescriptions to be taken over a prolonged period it may be appropriate to ask the General Practitioner's views before starting to ensure that this fits with the overall plans for the patient. ***Welsh Medical Committee***

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

Given that podiatrists do not have therapeutic knowledge and training across all conditions nor a potential role in treating all conditions it would seem reasonable for the focus of their prescribing to be on specified conditions from a specified formulary. ***Health and Social Care Board, Northern Ireland***

This will enable governance of prescriber to be robustly performed. It will enable training initial and ongoing to be tailored and of high quality. ***Kent Community Health NHS Trust***

I would like podiatrists to be able to prescribe for specific indications but from a limited formulary as I am concerned re limited knowledge of interactions/side effects etc. ***Doctor***

I work within diabetes & for podiatrist to have ability to prescribe pre-approved range of antibiotics would be invaluable. I would limit this to sub-specialised trained podiatrists only. ***Doctor***

From my experience with the governance of nurse independent prescribers in the community, there is a risk of non medical prescribers being tempted to prescribe outside their competence/scope of practice. NMPs sometimes do not realise that they do not have the competence to prescribe in a particular therapeutic area and there is danger to patients in the NMP's lack of knowledge of the drugs they prescribe. Podiatrists will never need to prescribe cardiovascular, anti-psychotic, chemotherapy medicines etc. Their drugs they need to prescribe are limited and can be easily captured in a formulary. Likewise the conditions are limited and should be specified. There must be a robust mechanism for timely updates to the formulary - both additions and deletions. A specified list of conditions and medicines then makes the patient safety role of the dispensing pharmacist (in a community pharmacy) more tenable. For example, as nurse independent prescribers can prescribe anything (CDs currently excepted) and the hands of a pharmacist are tied re competence/scope of practice of the NMP and therefore safety/appropriateness of the prescribed medicines for the individual patient. ***Pharmacist***

I feel that this would be safer for the public in that appropriate meds were applicably prescribed and that podiatrists didn't step outside of their professional boundaries. ***Podiatrist***

A limited number of conditions would be presented to a podiatrist that might not have been seen by a General Medical Practitioner. I would anticipate then that a specified formulary would be adequate at this stage to allow good practice to be developed without risks of error/clinical iatrogenesis. ***Podiatrist***

In some cases speed to obtain the medication is paramount. With IP the specialist can immediately prescribe allowing no delay to the patient by waiting on a Doctor to issue a prescription. ***Carer***

Option 3: Independent prescribing for any condition from a specified formulary
Option 3 was the least popular of the options to introduce independent prescribing with only 37 respondents selecting this option. Respondents identify some of the difficulties in a list of specified conditions but would prefer a limited formulary for use across the conditions that podiatrists treat.

> *Some of the proposed options may lead to complicated monitoring i.e. if drugs are allowable for some conditions but not for others this will be difficult to administer.* ***Accountable Officers Scotland – Working Group (NHS)***

> *I am against the prescribing by podiatrists (and other non-medical health professionals) from a full formulary. As a medical prescriber I am aware of the pitfalls of indiscriminate prescribing and remain unconvinced that the training available to the professions allied to medicine is adequate to allow for safe prescribing from a full formulary.* ***Doctor***

> *I believe limiting products promotes safer practice ensuring those prescribing become familiar with the available medications.* ***Nurse***

> *We treat a wide range of conditions which may be difficult to specify exactly.* ***Podiatrist***

> *This will give my podiatrist the ability to prescribe for my condition saving me having to see my GP and therefore saving the NHS money.* ***Patient***

Option 4: Independent prescribing for specified conditions from a full formulary
This option was not strongly supported, the comments refer to the operational requirement for podiatrists to work within the individual's scope of practice and competence rather than strategic requirements that enable local services to respond to local needs across a range of clinical groups.

> *The role for podiatrists within the healthcare team can be defined and a list of specified conditions would ensure clarity. However, please ensure that extended roles such as podiatric surgery are included.*
> *However, limiting independent prescribers to a formulary may limit their ability to successfully utilise their prescribing rights to the maximum benefit. We therefore believe that they should have access to any medicine, and for their prescribing to be monitored by the employing organisation.* ***Norfolk Community Health and Care NHS Trust***

> *Independent prescribing for any condition relating to the foot would dramatically improve the care of people with diabetes and foot problems as many patients are seen without immediate access to their GPs and so often there are significant delays in the patients receiving treatment. This can result in worsened outcomes including amputation where timely antibiotics are essential.* ***Doctor***

Option 4 will allow IPs to prescribe as necessary for the conditions in which they specialise ***Member of the Public***

A full formulary will prevent delays in future development but the prescribed items should be within the practitioner's scope of practice. ***Nurse***

The role for podiatrists within the healthcare team can be defined and a list of specified conditions would ensure clarity. However, please ensure that extended roles such as podiatric surgery are included. However, limiting independent prescribers to a formulary may limit their ability to successfully utilise their prescribing rights to the maximum benefit. We therefore believe that they should have access to any medicine, and for their prescribing to be monitored by the employing organisation. ***Pharmacist***

While Podiatrist have no wish to practice outside their field of expertise, restricting the formulary will be bad for patients as not all patients will respond to or tolerate all drugs. There must be alternatives hence the need for a range of drugs for specified conditions. ***Podiatrist***

Option 5: No change

Of the 1,210 responses received 7 respondents chose Option 5 No Change, and of those only 4 provided comments, which are provided below.

The consultation is not clear as to the distinctions between the different settings that podiatrists may work in. We would be content with option 2 in a secondary care setting as part of a multi-disciplinary team, but have significant concerns about primary care and independent sector, leaving us no alternative other than to say option 5. ***Consortium of Local Medical Committees for Lancashire & Cumbria***

I think the amount of practitioners/health care workers that are now able to prescribe potentially harmful medications is damaging and I regularly see errors in prescribing causing more workload and headaches for General Practitioners and additional consultations from the public asking us to endorse/agree the appropriateness of the prescribing. ***Doctor***

Much prefer to leave the responsibility with the GP. Safe and appropriate topical applications can be gotten from over the counter pharmacy or referred to GP for more serious issues. ***Podiatrist***

Podiatrists should not prescribe. ***Anon***

Responses to Question 2: Do you agree podiatrists should be able to prescribe a restricted list of Controlled Drugs with appropriate governance subject to separate amendment of appropriate Regulations?

Table 4: Question 2

CDs	Organisations										Individ's			
	Group 1		Group 2		Group 3		Group 4		All Orgs		Group 5		Total	
Option	Total	%	Total	%	Total	%	Total	%			Total	%	Total	%
Yes	6	43%	15	100%	5	83%	39	85%	65	80%	1052	93%	1,117	92%
No	1	7%	0	0%	0	0%	2	4%	3	4%	30	3%	33	3%
Partly	4	29%	0	0%	1	17%	4	9%	9	11%	24	2%	33	3%
Neither	3	21%	0	0%	0	0%	1	2%	4	5%	23	2%	27	2%
Total:	14		15		6		46		81		1129		1210	

The consultation invited views on allowing podiatrists to prescribe a very limited range of controlled drugs namely:

- Temazepam –anxiolytic for use in pre-surgery setting (Oral)
- Lorazepam – anxiolytic for use in pre-surgery setting (short term effect) (Oral)
- Diazepam – anxiolytic for use in pre-surgery setting (Oral)
- Dihydrocodeine – for use in pain management.

(Although podiatrists can sell or supply Dihydrocodiene via their exemptions, it is not subject to the signed order provision because of Misuse of Drug Regulations requirements for CDs.)

Controlled Drugs are subject to the additional requirements of the Misuse of Drugs Regulations 2001 which are the responsibility of the Home Office. If podiatrists are approved to prescribe CDs independently, amendments would need to be made to the regulations and their equivalents in NI following advice from the Advisory Council on the Misuse of Drugs.

Respondents who <u>Agreed</u> to allow podiatrists to prescribe from a limited list of Controlled Drugs

80% of organisations and 93% of individuals supported allowing podiatrists to prescribe from a limited list of controlled drugs. The appropriate use of the drugs in specific settings is cited beneficial to patients and an efficient use of podiatrist's skills when used within their scope of competence and with appropriate governance in place.

> *We agree that podiatrists should be able to prescribe the restricted list of Controlled Drugs subject to separate amendment of appropriate Regulations. However we also wish to highlight an imbalance as currently legislation does not allow pharmacist independent prescribers to prescribe controlled drugs and we believe this should be addressed as a matter of priority.* ***Royal Pharmaceutical Society***

> *Podiatrists are currently able to prescribe controlled drugs through supplementary prescribing. The proposed conditions of the release of anxiety in pre-surgery setting and in pain management in both surgery*

and musculoskeletal intervention should help to improve patient experience. ***NMC***

The PHA agrees podiatrists should be able to prescribe a restricted list of Controlled Drugs with appropriate governance subject to separate amendment of appropriate Regulations as this will benefit patients. ***Public Health Agency (Northern Ireland)***

Provided adequate safeguards are in place. Podiatrists are already able to prescribe some controlled drugs through supplementary prescribing. Clinicians are likely to see patients in severe pain and may be first point of contact. Patients who require opiates for pain control will not have to make an additional journey to a medical practitioner or face delay getting a prescription. This gives those podiatrists that are appropriately trained and working within their scope of practice requiring the use of anxiolytics and stronger pain control such as maybe required for invasive surgery and non-invasive nail surgery, the autonomy and flexibility to prescribes drugs which compliment and support their practice, without the need for referral to a GP/Consultant Physician, which would delay effective and timely management. ***British Health Professionals in Rheumatology***

Appropriate and timely management of pain reduces patient suffering and enhances recovery and rehabilitation Inclusion of controlled drugs would assist in this aspect of patient management. ***NHS Greater Glasgow and Clyde***

In my specialty of diabetic foot disease pain and anxiety are common problems that often requires use of controlled medicine and if this option is not available then the full effectiveness of care provided by podiatrist will not be achieved. ***Doctor***

The use of controlled drugs for a very short period of time with clearly defined treatment protocols would be of benefit to patients and aid pain control and rehabilitation. ***Podiatrist***

My podiatrist understands the need for pain relief and would use controlled drugs only in appropriate ways. ***Carer***

I suppose these are quite useful drugs and need to be used carefully but with reading the document if there is a need and the correct precautions are in place then seems a good idea. ***Member of the Public***

Respondents who <u>Disagreed</u> with allowing podiatrists to prescribe from a limited list of Controlled Drugs

4% of organisations and 3% of individuals disagreed with allowing podiatrists access to a limited list of controlled drugs. Among individual respondents, the majority of those who disagreed with this proposal were podiatrists that did not consider the list to be

sufficient for the needs of the profession in practice. Among organisations, the Royal College of Surgeons was the most prominent opponent to this proposal.

> *The College believes the current supplementary prescribing arrangements that exist for podiatrists to prescribe controlled drugs are fit for purpose and allow patients access to these drugs should they require them. We support the statement in the consultation document that such drugs should only be administered in the appropriate multi-disciplinary environment. We believe that any change to the current arrangements may lead to increased use outside the appropriate setting and team arrangements.* ***Royal College of Surgeons***

> *No, we do not believe that this list is appropriate, except perhaps in the case of sedation and pain relief following a procedure, but then again we assume this is currently the norm under a PGD or PSD. Therefore, we cannot see the benefit of podiatrists being able to prescribe these drugs in the medium or longer terms. In our area GPs are being strongly encouraged not to prescribe some of these drugs on cost, safety and clinical grounds, other than for palliative care. Why should podiatrists be allowed to do so? Who would be responsible for the monitoring of patients on these drugs? Who would be taking clinical responsibility? If the podiatrists are prepared to take full clinical responsibility, including dealing with anything that may go wrong (including addiction) and having appropriate medical defence cover then, and only then, may these proposals have some merit.* ***Consortium of Local Medical Committees for Lancashire & Cumbria***

> *Definitely not for controlled drugs, I do not think they are qualified or suitably policed to do this.* ***Doctor***

> *The route of administration of these is not specified. It is rare for anaesthetists to prescribe benzodiazepines as an oral premedication in orthopaedic surgery whether the patient is simply undergoing a regional block, general anaesthetic or a combination of the two.*
> *Intravenous administration of these drugs can be especially hazardous and patients may be placed at risk if this is permitted.* ***Other Health and Social Care Professional***

> *We don't need this.* ***Podiatrist***

> *If controlled drugs are necessary then a fully qualified medical practitioner should be responsible for the overall care of the patient.*
> ***Member of the Public***

Respondents who Partly agreed to giving podiatrists access to a limited list of Controlled Drugs

Of those respondents that only partly agreed with the proposals to give podiatrists a limited list of controlled drugs there were some key organisations including the BMA and the Royal college of General Practitioners that considered a GP or doctor more appropriate for the safe prescribing of controlled drugs.

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

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

> *Generally we should be trying to reduce the use of benzodiazepines but we support their short term use pre-op. We consider lorazepam to be sufficient for this purpose. We accept that patients may experience a lot of pain post-op and we would support prescription of a short supply of stronger analgesia such as dihydrocodeine.* ***RCGP Wales***

> *As lay representatives our concern is patient experience as well as patient safety. We can see that patients may benefit from swift access to anxiety-reducing drugs prior to surgery. However, we are also concerned of over, or incorrect-use of anaesthetics or major pain medication. We do not have the knowledge to comment on the question of specific drugs for these issues, and in the interests of patient safety we would like medically qualified clinicians opinions to be valued, in terms of the safety/ quality effectiveness of independent prescribing of controlled drugs. It is they who can say whether these drugs are safe for independent prescribing.* ***The Patient Liaison Group of the Royal College of Surgeons of England***

> *We agree that in principle podiatrists should be able to prescribe medicines for pre-surgery anxiety and dihydrocodeine for analgesia. For controlled drugs we believe that the appropriate indications for prescribing should be listed (as is currently the case for nurses). We would also question the need for 3 similar medicines for pre-surgery anxiety.* ***Norfolk Community Health and Care NHS Trust***

> *Controlled drugs are controlled for a reason and their prescription should be carefully regulated. Prescription from a very limited formulary is*

appropriate though. I do not think that Lorazepam/temazepam should be prescribable. I rarely prescribe these myself. They are addictive benzodiazepines and have been implicated in "date rape" cases. I am against any measure to increase the availability of these medicines. ***Doctor***

It is appropriate that podiatrists prescribe from a restricted list of controlled drugs eg some codeine based preparations as long as the use is recommended by recognized guidance (national and local). The examples given in the consultation document would need to be tightly governed to ensure appropriate use. Medicines management teams are currently working to ensure that the use of benzodiazepines is appropriate given the abuse potential. ***Pharmacist***

Podiatrists working within certain areas e.g. management of the high risk diabetic foot/ foot surgery/ MSK should be able to prescribe from a restricted list of controlled drugs with appropriate guidance for specific conditions with appropriate governance ***Podiatrist***

Responses to Question 3: Do you agree with making amendments to medicines legislation to allow podiatrists who are independent prescribers to mix medicines prior to administration or direct others to mix?

Table 6: Question 3

	Organisations										Individ's			
Mixing	Group 1		Group 2		Group 3		Group 4		All Orgs		Group 5		Total	
Option	Total	%	Total	%	Total	%	Total	%			Total	%	Total	%
Yes	8	57%	15	100%	5	83%	40	87%	68	84%	1019	90%	1,087	90%
No	0	0%	0	0%	0	0%	4	9%	4	5%	40	4%	44	4%
Partly	3	21%	0	0%	1	17%	1	2%	5	6%	8	1%	13	1%
Neither	3	21%	0	0%	0	0%	1	2%	4	5%	62	5%	66	5%
Total:	14		15		6		46		81		1129		1210	

This proposal was widely supported by 84% of organisations and 90% of individuals. A small proportion of respondents (4%) did not agree that mixing should be extended to podiatrists as mixing was unlikely to be frequent enough to maintain skills or would effectively allow unlicensed medicines to be issued. A smaller proportion (1%) supported the proposals subject to conditions such as mixing only taking place on rare occasions or from a defined list.

Respondents who <u>Agreed</u> to giving podiatrists rights to the mixing of medicines

We support the mixing of medicines only for which independent prescribing rights are given and where it is considered safe to do so. ***Royal College of Surgeons***

We support the amendment to allow podiatrists who are independent prescribers to mix medicines prior to administration or to direct others to

mix in order to ensure patients can access treatment without delay. ***The Royal Pharmaceutical Society***

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

It is standard practice among physicians to inject steroid mixed with local anaesthetic when performing intra articular injections. This gives immediate relief to the patient and confirms correct siting of the injection. Injecting the two substances separately increases infection risk as the syringe has to be changed and reattached to the needle. ***British Health Professionals in Rheumatology***

Reduction in patient discomfort would be achieved as would a minimising of the time taken to administer the medicines, thus lessening inconvenience for patients, should independent prescriber physiotherapists and podiatrists be granted permission to mix these medicines prior to administration. ***NHS Education for Scotland: AHP Team & Podiatry Education Advisory Group***

In some cases of severe infection, it is necessary to give intravenous or intramuscular antibiotics which will need special preparation by mixing medicines. The podiatrist needs to give these medicines urgently and will therefore need to mix medicines. ***Doctor***

This application is only expected to involve a small number of commonly used licensed medicines. One example is the mixing of Depo-Medrone (Steroid) and Local Anaesthetic (Lidocaine) prior to injection in the treatment of Musculoskeletal Conditions. This is commonly available also in a pre-mix preparation which is accessed via the exemptions but is limited to the type of anaesthetic that is mixed. The ability to have a longer acting anaesthetic would further enhance patient experience and treatment. ***Podiatrist***

This is standard practice and has not caused a problem in the many years mixing of medicines has been common practice. ***Pharmacist***

Respondents who <u>Disagreed</u> with giving podiatrists rights to the mixing of medicines

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

Unlikely to be a frequent enough event for skills to be maintained. ***Norfolk and Waveney Local Medical Committee***

I am not sure what is meant by mixing medications but not really relevant in UK practice. ***Doctor***

It wouldn't be necessary in our every day practice. ***Podiatrist***

Respondents who <u>Partly</u> agreed to giving podiatrists rights to the mixing of medicines

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

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

If a practitioner is being considered competent to independently prescribe, it would be illogical to say they cannot mix licensed medicines, based on the assumption that they have the knowledge of (and can take responsibility for) the properties and consequences of the drugs taken singularly or together, from a specified list/ for specified conditions. If full independence is granted then the potential for harm from mixing drugs increases, and would be of concern. ***The Patient Liaison Group of the Royal College of Surgeons of England***

The ability to mix some medicines (eg corticosteroid and local anaesthetics) prior to administration provides a much improved patient experience. However, this is one situation where a formulary of what can be mixed would be of use – even if in the form of guidelines from the professional body rather than legal statute. ***University of Brighton - Podiatry Dept***

Highly specialised podiatrists with the appropriate knowledge and skills and governance frameworks in place should be able to mix medicines prior to administration e.g. injectables such as anaesthetics and steroids. ***Podiatrist***

Responses to Question 4: Do you have any additional information on any aspects NOT already considered that could prevent the proposal for independent prescribing going forward?

22 organisations and 29 individuals responded to this question. The following are some examples that illustrate a few of the issues raised in response to this question:

Yes. We have concerns about the unknown cost of reducing the continuity of care that a patient has with their GP a step further. There is also significant risk to parallel prescribing. Patients can collect scripts from GPs at the same time as gaining other treatments, and can also get

repeat scripts, so it will be rare that this substantially adds costs into the system if the patient has a long term problem. We have seen a continuous reduction in continuity through successive policies aimed at choice and at some point we may see the end of the continuity that makes our practice work. This needs to be considered in the impact assessment in the light of evidence on continuity of care.
We are also concerned about CCG prescribing budgets and that GPs will lose more of their control over the indicative prescribing budget. GPs are currently pursuing prescribing savings actively through many means, including a computer-based system called "Scriptswitch". We are concerned that their hard work could be influenced by a prescriber outside the practice. The continuous increase in choice of providers, including prescribers, is undermining their ability to make savings through commissioning with a limited budget.
Patients attending or contacting a GP for a prescription will often have the opportunity to have other things done as part of their ongoing care eg flu jab, BP check, medication review. The latter must still be done, so less time is likely to be saved than predicted.
Royal College of General Practitioners

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

To prescribe appropriately, there is a need to make an accurate diagnosis so prescribing in a limited field would seem to be appropriate rather than no restrictions. The skill in prescribing has to be high. Nurses in Wales have been trained as Independent Prescribers but many of those trained are not using their skills. There is a danger that it becomes

another qualification but is not used for the purpose it was intended. In such circumstances, one must question whether the investment gives value for money.
Welsh Medical Committee

Getting easy access to GP records to check for drug interactions, allergies etc. to allow safe prescribing ***NHS Highland***

Careful consideration needs to be given in allowing existing HPC members opportunity to access conversion courses. This process needs careful scrutiny to ensure that for those practitioners grand-fathered into the HPC and where there is no evidence of previous undergraduate transcript of studies supporting prior assessment in LA and pharmacology a cautionary note should be exercised to ensure no baseline knowledge in these area is assumed. ***Council of Deans of Health***

I work with Podiatric colleagues daily and note their careful safe practice in the use of their limited exemption drugs and PGDs and also note the severe limitations to efficient practice that the limited drug list and PGD limitations impose currently.
Doctor

I strongly believe that only degree qualified Podiatrists should be able to gain the qualifications in IP. This should only include Podiatrists that have gained their qualification Podiatry from recognised schools of podiatry and should exclude Foot Health Practitioners who were 'grandparented' on to the HPC register by experience. This is because degree qualified Podiatrists have a sound knowledge of life sciences and will have the skills to be able to understand the science behind the pharmacology of the drugs.
Podiatrist

Responses to Question 5: Do you have any additional information on any aspects NOT already considered that could support the proposal for independent prescribing going forward?
33 organisations and 188 individuals responded to this question. The following are examples that illustrate some of the supporting evidence suggested in response to this question:

The Department may also wish to investigate the impact of personal health budgets. Patients could choose between direct access to a podiatrist who can prescribe, and attending a GP for a consultation. This could have unintended negative consequences, such as using up personal health budgets and loss of GP continuity.
British Medical Association (BMA)

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

As the profession progresses to providing seven day a week services, the additional accessibility to medicines as required by service users will increase. Having IP within the podiatry profession should help support patient self-management, support care in the community, prevent hospital admission and enable earlier supported discharge from acute services.
IP will also enable a more holistic approach to care, in which medicines compliment service user podiatry treatment in a cohesive and integrated clinical reasoning approach. The use of medicines, incorporated into a treatment plan with complimentary advice and other treatment modalities will make treatment more effective. Ultimately this will lead to more patient-centred care.
NHS Education for Scotland : AHP Team & Podiatry Education Advisory Group

Early intervention and treatment will result in increased treatment options, reduced chronicity of disease, thereby reducing the number of new and follow up appointments (both medical and therapist) and reduced hospital admissions.

Independent Prescribing will also support "Together for Health - a Five Year Vision for the NHS in Wales" Welsh Government (2011), Delivering Rural Health Care Services. Welsh Government (March 2011) and Setting the Direction - The Primary and Community Services Strategic Delivery Programme for Wales Welsh Assembly Government (2010).
Betsi Cadwaldr University Health Board

Following the successful recent NMP Clinical Audit on prescribing in the North West it has been demonstrated that the benefits to both patients and other key stakeholders from this pathway is significant. The results were based on 646 episodes of care of which 486 were podiatry episodes and 160 physiotherapy episodes. One important result was the demonstration that this showed a reduction in GP expenditure (as a true cash releasing product).
Podiatrist

This would be a positive in my area as the podiatrist is usually the person that has the greatest understanding of the need for antibiotics and dressings needed to prevent complications of the diabetic foot. They are part of the multidisciplinary team and should not have to waste time having prescriptions signed, this would enhance the service for the patient.
Nurse/Health Visitor

Responses to Question 6: Does the consultation stage Impact Assessment document give an accurate indication of the likely costs and benefits of the proposal?

41 organisations and 146 individuals responded to this question. The majority of respondents felt that the consultation stage impact assessment (IA) gives an accurate indication of the likely costs and benefits of the proposal. Of the remainder, most were suggestions of additional costs and potential benefits that could be included, although some were already included in the IA data.

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

> *In addition to our comments to Questions 4 and 5, there is insufficient evidence in the draft Impact Assessment, apart from a small generic study extrapolated to fit the current consultation. We are concerned that there is no mention of patient safety, in particular, with regards to patients notifying their GP of any changes.*
> ***British Medical Association (BMA)***

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

> *This proposal supports workforce redesign and will reduce duplication of assessments and interventions. It is anticipated that this will improve and service user and practitioner satisfaction. The costs and benefits of independent prescribing by podiatrists would be appropriate for this Health Board. A moderate investment would lead to effective care through the timely instigation of appropriate medicines management.*
> ***Hywel Dda Health Board***

> *The impact assessments accurately reflect the enhanced benefits to patient care and reduction in healthcare utilisation. Initial costs of education and supervision would be outweighed by long term benefits.*
> ***British Health Professionals in Rheumatology***

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

I feel the benefit is likely to be an under estimate as there will be a clear reduction in the number of healthcare professional that patient will require to see in future freeing up the time of doctors and the avoidance of delay for treatment for patient will have significant benefit that is difficult to quantify.
Doctor

Responses to Question 7: Can you offer any additional information to the consultation stage Equality Analysis document on how these proposals may impact either positively or negatively on specific equality characteristics, particularly concerning; disability, ethnicity, gender, sexual orientation, age, religion or belief, and human rights?
27 organisations and 152 individuals responded to this question. The responses generally expressed the view that proposals could offer individuals of specific 'equality characteristic' groups increased access to medicines, resulting in better overall health outcomes for patients. The following responses illustrate some examples of the supporting evidence suggested:

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

In relation to nursing homes, elderly care, mental health, areas of high health inequality etc where there are too few doctors to go round, having greater flexibility in the healthcare team as a whole would be welcomed.
In relation to diabetes, those patients who if their feet are left untreated can lose a limb, therefore prompt treatment is desirable.
Rural communities/elderly/housebound are better served than at present, if it saves on trips to the city for appointments.
However this may be achieved without completely independent prescribing, as issues noted in consultation may require referring on or other specialist knowledge. ***The Patient Liaison Group of the Royal College of Surgeons of England***

We think that independent prescribing by podiatrists will have a positive impact, particularly for disabled & older patients (and their carers) by reducing the need for them to make an additional visit / appointment to their GP surgery to obtain a prescription. ***Bromley Healthcare Community Interest Company Ltd.***

Independent prescribing would be likely to offer patients more equitable access to care from prescribing podiatrists or physiotherapists as the IP mechanism might enable existing mechanisms, such as the use of PGDs, to be superseded over time. PGDs currently tend to operate

inconsistently over different geographical areas and across different PCTs. Independently prescribing professionals such as podiatrists or physiotherapists would also be empowered to provide services and care closer to patients' home, in line with the White Paper on Health & Social Care, saving both time and money, thus enabling a better quality of life for patients.
Pharmacist

Obviously patients with foot ulcers may well be housebound and so GPs are unlikely to be very involved in the management - so they have to rely anyway on the opinion of the podiatrist re the need for antibiotics and pain relief
Doctor

Responses to Question 8: Can you offer any additional information on how these proposals may impact either positively or negatively on any specific groups e.g. students, travellers, asylum seekers, children and young people, homeless and offenders?
38 organisations and 199 individuals responded to this question. The responses generally expressed the view that proposals could offer certain other equality groups increased access to medicines resulting in better overall health outcomes for patients. The following responses illustrate examples of some of the supporting evidence suggested:

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

Diabetic patients with neuropathy and ischemia are very vulnerable patients. In that they have neuropathy, they have lost nature's protection against external agents. If one adds another stratum of vulnerability such as being homeless then such patients become extremely vulnerable to diabetic foot problems.
Doctor

Both Podiatry and Physiotherapy prescribers across the North West provide the first line specialist management of hard to reach patients in community. For example, homeless, drug users, vulnerable fragile elderly in nursing homes and residential care as well as many patients lacking with compromised mental capacity. For such patients rapid access to a single one stop episode of care can be critical to the outcome of any intervention. Access to Independent prescribing here will provide a significant improvement in the patient journey and in the quality and responsiveness of care received. ***North West Allied Health Professionals Non Medical Prescribing Network.***

As autonomous practitioners both professions should be able to provide autonomous service delivery enabling new roles and new ways of working to improve the quality of care the patient receives. ***NHS Greater Glasgow and Clyde***

Access to community podiatrists with the skills and prescribing powers commensurate to their competency will ensure hard to reach groups access medicines in an effective efficient manner, irrespective of location. ***Cardiff and Vale UHB Podiatry***

Podiatrists work and volunteer in outreach centres that cater for and support homeless and other disadvantaged people, many of whom have multiple and complex health care issues. The ability to prescribe POMs will allow Podiatrist to increase the breadth and depth of the health care services they can offer to these vulnerable groups within the community, many of whom are not registered with a GP. Inter-professional communication, following contact with these types of patient will only enhance overall coordination of and improvement in their health care.
Podiatrist

Under the proposals, patients may only require attention from one clinician. Timely provision of care may be advantageous to groups who may find the patient experience traumatic, confusing or alarming e.g. Asylum seekers or children.
Patient

General Comments:

1. Comments relating to the Outline Curriculum Framework for Education programmes

31 organisations and 141 individuals commented on the Outline Curriculum Framework for Education programmes. The following are a sample of the comments provided in response to this document.

If podiatrists are to prescribe there must be full education available on pharmacology, pathophysiology and drug interactions.
Royal College of General Practitioners, Wales

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

The indicative content would benefit from having learning outcomes about maintaining fitness to practise and on-going CPD specific to IP.

The curriculum should also enable students to identify sustainable infrastructure to support IP and repeated prescriptions. IP requires administrative processes in addition to the clinical skills. Without the supportive systems and processes the IP practitioners impact and effectiveness will be restricted.
NHS Education for Scotland : AHP Team & Podiatry Education Advisory Group

I have worked with nurse prescribers and value their role, I work with some physios and podiatrists whom I would be happy to see prescribing but am concerned that there are others who I would be less happy to have wide ranging prescribing rights.
Doctor

The outline curriculum framework reflects much of the work already undertaken for AHP and nursing non-medical prescriber professional groups. It is an extension of the existing supplementary prescribing framework already in use by physiotherapy, podiatry and radiography, with enhanced safe guards and requirements for independent prescribing, and will thus be a familiar format for HEI providers. Many HEI providers already provide SP and IP for nurses and pharmacists, and the new outline curriculum framework could be adopted readily by HEI providers once IP for podiatrists and physiotherapists becomes possible. It thus also lends itself to future work to draw together curriculum frameworks from a range of NMP groups.
Podiatrist

Allowing podiatrist to have this skill, will benefit the patient in various ways. From a nursing prospective, it will allow the systemic steam-lining of the patients journey, through theatre and Out patients. For the patient it will provide analegisia to be targeted at their needs and requirements without having to top this up with a GP prescription. ***Nurse***

2. Comments relating to the Outline Curriculum Framework for Conversion Programmes

30 organisations and 130 individuals commented on the Outline Curriculum Framework for Conversion Programmes. The following are a sample of the comments provided in response to this document.

Clear guidance for supplementary prescribers to identify what they need to do to up-skill to independent prescribing is required, as they will have already covered the same theoretical content as independent prescribers.
The curriculum, while it maybe multiprofessional, requires to guide and support students to evolve within their scope of practice. This has been challenging within the existing supplementary prescribing courses. An emphasis on supporting students to self-direct and apply the principles of

prescribing into their current and future context is needed e.g. students having the opportunity to discuss/ explore medicines directly pertinent to their post/ role. The work-based element of the course should be designed to support the student into current/ new service provision. The curriculum should also enable students to identify sustainable infrastructure to support IP and repeated prescriptions. IP requires administrative processes in addition to the clinical skills. Without the supportive systems and processes the IP practitioners impact and effectiveness will be restricted.
Learning from other conversion courses is important here.
NHS Education for Scotland : AHP Team & Podiatry Education Advisory Group

Again, this is robust and provides appropriate reassurance in relation to existing SPs extending their practice and requiring further education.
Hywel Dda Health Board

SCoR supports the provision of a conversion curriculum framework. We believe it is important to demonstrate clearly the requirements for further training and education in line with the additional professional responsibilities that come with the role of independent prescriber.
The Society and College of Radiographers (SCoR)

It is acknowledged that there is a need for further training and education and the additional responsibilities that come with the role of an independent prescriber. It also puts in place the necessary safe guards ensuring continuity in prescribing practice prior to approval and validation. ***Podiatrist***

Podiatrists undertaking the current non-medical prescribing course to become Supplementary Prescribers are required to undertake an exam to assess their 'pharmacological knowledge and its application to practice' and achieve a minimum 80% pass. This is identical to the exam undertaken by Nurses and Pharmacists to become Independent Prescribers. Therefore, this component of the assessment strategy should not be necessary to convert from Supplementary Prescriber to Independent Prescriber. ***Podiatrist***

I think the need for a conversion programme from SP to IP is essential: it demonstrates the importance of the several differences between being a SP and an IP, emphasizes the additional responsibilities inherent within acting as an IP, and ensures that the necessary checks and balances that provide and support patient safety are put in place from the earliest stage of HCP training.
Member of the public

3. Comments relating to the Practice Guidance
27 organisations and 115 individuals commented on the Practice Guidance. The following are a sample of the comments provided in response to this document.

> *The British and Irish Orthoptic Society believes that the professional guidance documents for podiatry offer clear guidance for practitioners as well as providing a clear governance structure.*
> ***The British and Irish Orthoptic Society***

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

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

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

> *This document provides guidance to both NHS and private practitioners, offering a comprehensive governance structure for prescribing medicines. I fully support the recommendations and requirements made within this report and its appendices, and welcome the publication in the future of the proposed NPC New Prescribers Competency Framework for all prescribers.*
> ***Podiatrist***

4. Do you have any other comments you would like to make in relation to this consultation?
23 organisations and 68 individuals made other comments in relation to the consultation. The following are a sample of the comments provided in response to this question.

> *Only to highlight that these proposals are an exciting and valuable addition to current practice. Equally there is value in obtaining medicines via the GP/Consultant as a safe guarding mechanism.*

Fostering multi-professional engagement and support should be a key part of this development. ***University of Brighton - Podiatry Dept***

The challenge for the profession of podiatry will be to ensure that sufficient numbers of practitioners undertake the additional training and education necessary to carry out these tasks, and to ensure that these skills are fully utilised in practice.
It will be crucial for the current workforce to be able to access conversion programmes if these changes are to be felt by patients. It will therefore be vital that LETBs and other education commissioners support current podiatrists in practice to re-skill/enter conversion programmes in order to make the changes and benefits envisaged by these proposals to become a reality for patients.
Council of Deans of Health

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

BCUHB welcomes the opportunity to consult on the proposals and looks forward to the introduction of Independent Prescribing for Podiatrists.
Betsi Cadwaldr University Health Board

This is a welcome opportunity to influence change and allow a natural development in the scope of practice for podiatrists, enhancing good use of resources and enhancing the patient journey and experience.
Northern HSCT

Themes Arising from the Consultation

Several themes emerged among the written responses to the consultation. The range of themes mainly reflected the benefits of the proposals. There were expressions of concern or queries relating to monitoring and governance. A summary of the focus of each theme is outlined below.

Patient benefit
There were 395 comments from individual respondents indicating that the introduction of independent prescribing by podiatrists would have positive benefits to patients. More specific comments about the benefit of increased patient choice, improved patient experience, increased standard of care and improved timeliness of treatment were also frequently referenced;

Patient safety
There were 94 comments expressing a belief that the proposed changes would be safe or increase patient safety. The reasons given include the specialist knowledge and

skills that podiatrists have in relation to treating the foot and lower limb and experiential evidence with regard to nurse and pharmacist independent prescribing.

Risk to patent safety
Comments from 20 respondents expressed concerns regarding patient safety due to difficulties in accessing patient information, knowledge of drug interactions and side effects.

Service redesign
Service redesign was a strong theme among respondents with 153 comments. Comments supporting the benefits of service redesign included the streamlining of care pathways, workforce redesign, multi-disciplinary team flexibility, improved efficiency and responsiveness to patient needs in community care.

Training/Education
Comments in regard to training and education (228) included expressions of confidence in the education and training of podiatrists, a lack of confidence in the education and training of podiatrists and specific comments regarding the proposed IP curricula.

The majority of the comments under this heading expressed confidence in the training and education of podiatrists. For example:

> *… Podiatrists are highly trained practitioners and prescribing with additional training should be within their competence and could greatly enhance patient care. Current delays in podiatric treatment/deterioration due to delays in prescribing by medical practitioners who often have not even seen the patient and are relying on information from the podiatrist are unacceptable and compromise patient care. These delays could be alleviated if podiatrists became independent prescribers with additional training. I work closely with independent nurse prescribers within a hospital setting in acute medicine and the benefits are enormous.* ***Doctor***

The comments expressing concerns about podiatrist's existing training/education in medicines included:

> *As a medical prescriber I am aware of the pitfalls of indiscriminate prescribing and remain unconvinced that the training available to the professions allied to medicine is adequate to allow for safe prescribing from a full formulary.* ***Doctor***

Comments regarding the Independent prescribing outline framework curricula were mostly positive, asserting that the documents seem comprehensive and relevant.

Governance
Comments in regard to governance included support for the governance framework in the SCP and ICP Practice Guidance and concerns about the monitoring of practitioners by the regulator and in private practice.

> *This document [practice guidance] provides guidance to both NHS and private practitioners, offering a comprehensive governance structure for prescribing medicines.* ***Podiatrist***
>
> *There is a need to ensure the robust governance of any profession moving forward in relation to independent prescribing. This may be particularly troublesome within the private sector.* ***Accountable Officers Scotland - Working Group [NHS]***

Scope of Practice

Most comments indicated an understanding that podiatrists would prescribe only within their scope of practice. There were a small number of respondents that expressed concerns about practitioners working beyond their scope of practice and the risks associated with it.

Access to medicines

Comments in relation to access to medicines indicated improved patient's access to the medications needed, reduced GP time and appointments and improved services particularly for disadvantaged or marginalised groups that struggle to access mainstream health services, e.g. the homeless or travellers.

Next Steps

Following Public Consultation

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

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

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

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

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

Scope of Podiatrist Independent Prescribing

The scope of prescribing practice for podiatrists is bounded by their professional practice and scope of competence:

"The professional bodies [the SCP and the IoCP working collaboratively] agree that it is necessary to direct those members, who are engaged in the practice of independent prescribing, to ensure that they concern themselves only with those medicines which are relevant to the treatment of disorders affecting the foot, ankle and associated structures, in line with current practice and consistent with published professional guidance"

Amendments to Legislation and NHS Regulations

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

Appendices

Appendix A Consultation Dissemination List

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

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

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

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

Group 2 Organisations	Category
Allied Health Professions Federation	AHP Professional Bodies
British and Irish Orthoptic Society	AHP Professional Bodies
British Association of Dramatherapists	AHP Professional Bodies
British Association of Art Therapists	AHP Professional Bodies
British Association of Prosthetists and	AHP Professional Bodies

Group 2 Organisations	Category
Orthotists	
British Dietetic Association	AHP Professional Bodies
Chartered Society of Physiotherapy	AHP Professional Bodies
College of Occupational Therapists	AHP Professional Bodies
College of Paramedics	AHP Professional Bodies
Institute of Chiropodists and Podiatrists	AHP Professional Bodies
Royal College of Speech and Language Therapists	AHP Professional Bodies
Society and College of Radiographers	AHP Professional Bodies
Society of Chiropodists and Podiatrists	AHP Professional Bodies
Association of Professional Music Therapists	AHP Professional Bodies

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

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

Group 4 Organisations	Category
Prosthetics, Orthotics & Rehabilitation Technology–Education & Research (PORT - ER)	Patient Representative Group
Specialised Healthcare Alliance	Patient Representative Group
Spinal Injuries Association	Patient Representative Group
Thalidomide Society	Patient Representative Group
Lindsay Leg Club Foundation	Patient Representative Group

Appendix B List of Controlled Drugs

The prescriptions of controlled drugs:
Preparations which are subject to the prescription requirements of the Misuse of Drugs Regulations 2001 are distinguished in the BNF with the symbol [CD] (controlled drugs). Prescription of Controlled Drugs must be in ink or otherwise indelible and must be signed and dated (computer generated date is not acceptable, but a date stamp is). This must also specify the prescriber's address.
In the prescriber's handwriting:

1. Name and address of patient
2. Preparation strength and form
3. Total quantity (unit in words and numbers)
4. The dose

This does not apply to prescriptions of temazepam (except in certain preparations, see BNF).

The prescription is valid for 13 weeks after the date noted on by the prescriber.
The College of Podiatrists and the Institute of Chiropodists and Podiatrists have proposed the following Controlled Drugs for consideration as part of the Public Consultation for Independent Prescribing.

1. Temazepam –anxiolytic commonly in pre-surgery setting (Oral)
2. Lorazepam – anxiolytic commonly in pre-surgery setting (short term effect) (Oral)
3. Diazepam - – anxiolytic commonly in pre-surgery setting (Oral)
4. Dihydrocodeine – for pain management in both surgery and musculoskeletal setting

Consideration of any contradictory effects of these drugs would need to be considered, (e.g. In 1 person in 10,000 the drug may have the opposite effect than that intended).

The Medicines Committee, College of Podiatrists strongly recommends that all use of Controlled Drugs by Independent Prescribers is undertaken as part of a multi-disciplinary team approach in appropriate setting where access to immediate life support facilities and personnel are directly available. The Professional Body Guidance around the use of Controlled Drugs strongly recommends the use of a Standard Operating Procedure for the management of Controlled Drug use. An example of what should be included is listed below.

- The standard operating procedures must include:
  - Ordering and receipt of CDs
  - Assigning responsibilities
  - Where the CDs are stored
  - Who has access to the CDs
  - Security in the storage and transportation of CDs as required by misuse of drugs legislation
  - Disposal and destruction of CDs
  - Who is to be alerted if complications arise
  - Record keeping, including:
  - Maintaining relevant CD registers under misuse of drugs legislation
  - Maintaining a record of the CDs specified in Schedule 2 to the Misuse of Drugs Regulations 2001 that have been returned by patients

- The Standard Operating Procedure (SOP) should also include:
  - Responsibilities within the practice team
  - Validation by healthcare organisation and date
  - Review period, e.g. one, two or three years
  - Lead author and named people contributing to the SOP

Appendix C General Data on Respondents

Table 6:Respondents' profession

Option	Total	%
Physiotherapist	10	1%
Podiatrist	796	66%
Other Allied Health Professional	22	2%
Doctor	30	2%
Nurse/Health Visitor	29	2%
Pharmacist	13	1%
Optometrist	2	0%
Midwife	0	0%
Other Health and Social Care Professional (please specify below)	34	3%
Not Answered	274	23%
Total	1210	100%

Table 7: Respondents' prescribing qualifications

Option	Total	%
supplementary prescriber	147	12%
independent prescriber	51	4%
non prescriber	649	54%
Not Answered	363	30%
Total	1210	100%

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

Option	Total	%
as a patient	75	6%
as a carer	3	0%
as a member of the public	102	8%
as a health or social care professional	862	71%
on behalf of an organisation	81	7%
Not Answered	87	7%
Total	1210	100%

Table 9: Respondents' country

Option	Total	%
England	912	75%
Scotland	90	7%
Wales	57	5%
Northern Ireland	15	1%
Other	6	1%
Not Answered	130	11%
Total	1210	100%

Appendix D List of Organisation Responses by Group

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

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

Organisation	Q.1 Independent Prescribing	Q. 2 Controlled Drugs	Q. 3 Mixing Medicines
RCGP Wales	Option 2	Partly	Yes
Royal Society for Public Health	Option 1	Yes	Yes
Royal College of General Practitioners	Option 2	(No choice selected)	(No choice selected)
British Health Professionals in Rheumatology	Option 1	Yes	Yes
Royal College of Surgeons	Option 2	No	Yes
British Medical Association (BMA)	Option 2	Partly	Partly
Welsh Medical Committee	Option 2	Neither	Neither
The Patient Liaison Group of the Royal College of Surgeons of England	Option 2	Partly	Partly
College of Optometrists	Option 1	Neither	Neither
Public Health Agency (Northern Ireland)	Option 1	Yes	Yes
Nursing and Midwifery Council	Option 1	Yes	Yes
Health Professions Council	Option 1	Neither	Neither
The Royal Pharmaceutical Society	Option 1	Yes	Yes
Care Quality Commission	Option 1	Yes	Yes

Group 2: AHP representative/advisory bodies

Organisation	Q.1 Independent Prescribing	Q. 2 Controlled Drugs	Q. 3 Mixing Medicines
British Association of Art Therapists	Option 2	Yes	Yes
Society of Chiropodists and Podiatrists	Option 1	Yes	Yes
Bournemouth and District Branch, Society of Chiropodists & Podiatrists	Option 1	Yes	Yes
NE SHA AHP Collaborative	Option 1	Yes	Yes
Allied Health Professions - Professional Advisory Board	Option 1	Yes	Yes
The Society and College of Radiographers (SCoR)	Option 1	Yes	Yes
SCP Buckinghamshire Branch	Option 1	Yes	Yes

Organisation	Q.1 Independent Prescribing	Q. 2 Controlled Drugs	Q. 3 Mixing Medicines
Society of Chiropodists and Podiatrists Northern Ireland Branch	Option 1	Yes	Yes
Institute of Chiropodists and Podiatrists	Option 1	Yes	Yes
The National AHP Patients Forum	Option 1	Yes	Yes
The Society and College of Radiographers (Supply, Administration & Prescribing of Medicines Group)	Option 1	Yes	Yes
The British Dietetic Association	Option 1	Yes	Yes
Allied Health Professions Federation	Option 1	Yes	Yes
SCP Faculty of Management NI	Option 1	Yes	Yes
The British and Irish Orthoptic Society	Option 1	Yes	Yes

Group 3: Educational bodies/establishments

Organisation	Q.1 Independent Prescribing	Q. 2 Controlled Drugs	Q. 3 Mixing Medicines
University of Brighton - Podiatry Dept	Option 1	Partly	Partly
Health, Ethics and Law network, University of Southampton.	Option 1	Yes	Yes
Accountable Officers Scotland - Working Group	Option 3	Yes	Yes
School of Health Sciences, University of Ulster, Jordanstown Campus, Belfast, Northern Ireland.	Option 1	Yes	Yes
Council of Deans of Health	Option 1	Yes	Yes
NHS Education for Scotland : AHP Team & Podiatry Education Advisory Group	Option 1	Yes	Yes

Group 4: Service Providers

Organisation	Q.1 Independent Prescribing	Q. 2 Controlled Drugs	Q. 3 Mixing Medicines
NHS Hampshire	Option 2	Yes	Yes
All Wales Physiotherapy Managers Committee	Option 1	Yes	Yes
Aneurin Bevan Health Board	Option 1	Yes	Yes
Scottish Diabetes Group - Foot Action Group	Option 1	Yes	Yes
Betsi Cadwaldr University Health Board	Option 2	Yes	Yes
North West Allied Health Professionals Non Medical Prescribing Network.	Option 1	Yes	Yes
Derbyshire Community Health Services NHS Trust	Option 1	Yes	Yes
Bradford District Care Trust	Option 1	Yes	No
Kent Community Health NHS Trust	Option 2	Yes	Partly
Tiptoe Foot Care	Option 1	Yes	Yes
Podiatry Rheumatic Care Association (PRCA)	Option 1	Yes	Yes
NHS Cumbria/Cumbria Partnership NHS Foundation Trust	Option 1	Yes	Yes
NHS Grampian	Option 1	Yes	Yes
Central Essex Community Services	Option 2	Partly	Yes
Central London Community Healthcare NHS Trust	Option 1	Yes	Yes
Hywel Dda Health Board	Option 1	Yes	Yes
NHS Fife	Option 1	Yes	Yes
Community Health services in Bedfordshire	Option 1	Yes	Yes
The Forest Podiatry and Physiotherapy Clinic Ltd	Option 1	Yes	Yes
Oxleas NHS Trust	Option 2	Yes	Yes
Salford Royal NHS Foundation Trust	Option 1	Yes	Yes
South Warwickshire Foundation Trust	Option 1	Yes	Yes
NHS Greater Glasgow and Clyde	Option 1	Yes	Yes

Organisation	Q.1 Independent Prescribing	Q. 2 Controlled Drugs	Q. 3 Mixing Medicines
Bridgewater NHS community healthcare Trust (Halton and St Helens Division)	Option 1	Yes	Yes
Birmingham Community Health Care NHS Trust	Option 1	Yes	Yes
Norfolk and Waveney Local Medical Committee	Option 2	No	No
Typharm Limited	Option 1	Yes	Yes
Wiltshire Community Health Services	Option 1	Yes	Yes
NHS Highland	Option 1	Yes	Yes
Consortium of Local Medical Committees for Lancashire & Cumbria	Option 5	No	No
NHS Hertfordshire	Option 1	Partly	Yes
Zeon Healthcare Limited	Option 4	Yes	Yes
Cardiff and Vale UHB Podiatry	Option 1	Yes	Yes
Cambridgeshire Community Services	Option 1	Yes	Yes
Hounslow and Richmond Community Healthcare	Option 1	Yes	Yes
Royal Wolverhampton NHS Trust	Option 1	Yes	Yes
Sussex Community NHS Trust	Option 1	Yes	Yes
United Kingdom Accreditation Service	Option 2	Yes	Neither
Norfolk Community Health and Care NHS Trust	Option 4	Partly	Yes
NHS Forth V alley	Option 1	Yes	Yes
Northern HSCT	Option 1	Yes	Yes
Salford Royal Foundation Trust	Option 1	Yes	Yes
Health and Social Care Board, Northern Ireland	Option 2	Partly	No
Bromley Healthcare Community Interest Company Ltd.	Option 1	Neither	Yes
University Hospital of South Manchester NHS Foundation Trust	Option 1	Yes	Yes
Foot In Diabetes UK	Option 1	Yes	Yes