

Title: PROPOSALS TO INTRODUCE INDEPENDENT PRESCRIBING BY PODIATRISTS IA No: 1019 Lead department or agency: Department of Health Other departments or agencies: MHRA Commission on Human Medicines Health Professions Council	Impact Assessment (IA)		
	Date: 05/07/2012		
	Stage: Final		
	Source of intervention: Domestic		
	Type of measure: Other		

Summary: Intervention and Options **RPC Opinion:**

Cost of Preferred (or more likely) Option			
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, Measure qualifies as One-Out?
£1.6m	£0m	£0m	

What is the problem under consideration? Why is government intervention necessary?
 Current regulations do not permit podiatrists to independently prescribe medicines. Podiatrists are currently able to supply and administer medicines from a specified list of exemptions to the Medicines Act and supplementary prescribe. This has been shown to exhibit inefficiencies in delivery and require unnecessary additional activity for doctors. There is scope to substantially increase flexibility and access to care for patients with the introduction of independent prescribing for podiatrists. Being able to independently prescribe may improve all three domains of quality of care: safety, patient experience and effectiveness, by liberating podiatrists to maximise the benefit they have to offer patient care.

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

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)
 Option 1 - Independent prescribing for any condition from a full formulary
 Option 2 - Independent prescribing for specified conditions from a specified formulary
 Option 3 - Independent prescribing for any condition from a specified formulary
 Option 4 - Independent prescribing for specified conditions from a full formulary
 Option 5 - Do nothing / No change
 The preferred option is option 1.

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

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

Signed by the responsible Minister: _____ Date: 11th Sept 2012

Summary: Analysis & Evidence

Policy Option 1

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

FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2012	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £8.2m	High: £44.9m	Best Estimate: £26.6m

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	£0m	£0.17m	£1.66m

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

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

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

- Time commitment from podiatrists to attend educational programmes
- Complexities of governance of the professions

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	£0.99m	£9.86m
High	Optional	£4.66m	£46.59m
Best Estimate	£0m	£2.82m	£28.23m

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

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

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

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

Key assumptions/sensitivities/risks

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

Discount rate (%)

3.5

BUSINESS ASSESSMENT (Option 1)

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

Evidence Base (for summary sheets)

Background

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

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

As a result of these recommendations an engagement exercise was held between 3 September – 26 November 2010 to provide background information and seek views on the possible changes to medicines legislation that would enable appropriately trained podiatrists to prescribe independently. The response to the engagement exercise was overwhelmingly positive. There were 177 responses with 91% supporting independent prescribing for podiatrists.

In recent years independent prescribing responsibilities have been extended to Nurse Independent Prescribers, Pharmacist Independent Prescribers and Optometrist Independent Prescribers. The recent evaluation of nurse and pharmacist independent prescribing by the University of Southampton and Keele University¹ concluded that 'nurse and pharmacist independent prescribing in England is becoming a well-integrated and established means of managing a patient's condition and giving him/her access to medicines'.

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

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

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

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

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

Policy context

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

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

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

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

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

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

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

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

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

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

² Department of Health (2010), *Equity and Excellence: Liberating the NHS*, London
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

³ Department of Health (2008), *High quality care for all: NHS Next Stage Review final report*, London
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

⁴ Department of Health (2008), *NHS Next Stage Review: Our vision for primary and community care*, London
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085937

⁵ Department of Health (2008), *A high quality workforce: NHS Next Stage Review*, London
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085840

⁶ Department of Health (2008), *Framing the contribution of allied health professionals: Delivering high-quality healthcare*, London
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089513

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

www.dhsspsni.gov.uk/ahp-strategy-feb-2012.pdf

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

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

The following relates to Scotland:

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

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

The following relate to Wales:

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

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

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

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

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

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

Rationale for intervention

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

Policy objective

The objective of introducing independent prescribing for podiatrists is to enhance patient care by improving access to medicines through an increased and more flexible approach. In turn, implementation will address the three domains of quality: safety, patient experience and effectiveness. It is important to recognise and state that if policy and legislative changes occur in the future it is not anticipated that all podiatrists would become independent prescribers as independent prescribing will be a voluntary addition to the individual's professional capacity. Only those clinicians who are already working at a highly skilled and specialist level, in a

relevant clinical/service area will progress to independent prescribing. This is not about individual career development, it is about improving patient care/access to medicines through service re-design/delivery and must not compromise patient safety at any point. Podiatrists who have completed the relevant post-registration training may currently prescribe as supplementary prescribers, and supply and administer medicines through the exemptions mechanism; the progression to independent prescribers' status is an addition to those responsibilities.

Patient safety

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

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

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

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

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

Patient experience

Podiatry offers many innovative services, improving access, choice and convenience. Some examples include podiatry-led high-risk foot protection teams, vascular triage services and combined multi-disciplinary therapy teams supporting patients at home to prevent emergency admission to hospital.

Some of these innovative services make use of the existing mechanisms to provide patients with greater access to medicines. However, there is potential for some of these services to further improve access and thereby empower patients to make their own choices about health and healthcare. For example, a patient with foot pain may appropriately consider self-referring

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

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

to podiatry, but if they perceive a need for a medicine they must see their GP, independent nurse prescriber or pharmacist prescriber instead of, or in addition to, the podiatrist. The introduction of independent prescribing by podiatry services could avoid the inconvenience for patients of multiple appointments with associated duplication of travel, parking and time off work. Furthermore, streamlining patient care in this way could improve patient access to prescriptions and offer accessible advice regarding dose alteration and concordance with existing medicines. Patients often access these services between visits to their GP or hospital doctor, and the potential to reduce inefficiencies and avoidable appointments would facilitate an infrastructure that enables frontline staff to lead change for patient benefit, providing comprehensive care closer to home and facilitating greater outreach of hospital and primary care services. For example, extending access to medicines among traditionally hard-to-reach and rural populations through enhanced services has the potential to improve access as well as reducing health inequalities. Older people, disabled, traveller and ethnic minority groups are likely to benefit from enhanced, more accessible and responsive services being offered from a variety of locations, closer to home.

Effectiveness

Effectiveness refers to the outcomes of clinical care, avoidance of ill health and helping people to stay healthy. Under the present arrangements, the extent to which the implementation of non-medical prescribing promotes effective care varies according to the clinical pathway. In some cases, the existing mechanisms enable highly effective care. For example, a podiatrist performing nail surgery in the community can use exemptions to administer local anaesthetic for surgery and, if necessary, antibiotics to treat uncomplicated local infection.

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

In numerous clinical pathways, podiatrists now deliver care that was previously provided by doctors, or work collaboratively across traditional boundaries. Podiatrists undertake surgery and lead multidisciplinary community-based foot protection teams, who respond to the needs of patients with high-risk lower-limb pathology, often without medical intervention. In these clinical pathways, investigations, diagnostic and/or therapeutic procedures and appropriate onward referral can occur as it would in medically led care. Podiatrists deliver high-quality care but this is often in the absence of optimal medicines management. Consequently the service provided by the podiatrist is less comprehensive and therefore less effective than it could be. A lack of access to appropriate prescribing or medicines supply mechanisms also means that innovative care pathways may not be developed at all.

A podiatrist is often the multidisciplinary team member with whom the patient spends the most time. Appointments may last 30 to 60 minutes or longer, on multiple days over multiple weeks. This allows considerable opportunity for discussion of shared outcomes with a patient, improving adherence and patient safety. This can enhance the safe and effective use of medicines⁹, potentially reducing waste and improving outcomes for patients with existing

⁹ National Institute of Health and Clinical Excellence (2009) *Nice Guidance, Medicines Adherence*, London

disease. It also has the potential to help improve health and well-being through better long-term use of medicines.

Overall the introduction of independent prescribing by podiatrists will:

- improve the quality of service to patients/public without compromising patient safety
- demonstrate value for money by improving patient access and choice reducing avoidable duplication and inefficiencies and streamlining service delivery
- make it easier for patients/public to get the medicines they need
- increase patient choice and convenience in accessing medicines
- free up the time of doctors to conduct other clinical work
- potentially reduce unnecessary appointments and waiting lists
- contribute to the introduction of more flexible, collaborative team working
- maximise the benefits of fully utilising diverse professional skills

Consultation and Considered Options

An engagement exercise was held over 12 weeks between 3 September 2010 and 26 November 2010. The engagement exercise followed recommendations in the 2009 *Allied health professions prescribing and medicines supply mechanisms scoping project report*¹⁰. The response was overwhelmingly positive, with 91% support for extending independent prescribing by podiatrists¹¹. The exercise gathered significant information on the key issues and posed some further questions in respect of independent prescribing by podiatrists to inform a public consultation.

Public consultation

In September 2011, Ministers agreed to a public consultation on proposals for independent prescribing by podiatrists, the mixing of medicines and a limited list of controlled drugs. The proposals specifically excluded the independent prescribing of unlicensed medicines following consideration of feedback from the engagement exercise. The consultation was held jointly by the Department of Health and the Medicines and Healthcare products Regulatory Agency (MHRA) between 15th September 2011 and 30th December 2011¹².

In total 1,210 responses to the consultation were received, with responses from all four countries of the UK. There were 180 responses from patients, carers or members of the public and 862 from health or social care professionals including; doctors, nurses, pharmacists, and AHPs. Responses were received on behalf of 81 organisations.

The responses to the consultation show very strong support for introducing independent prescribing for podiatrists, with only 7 of the 1,210 respondents (less than 1%) preferring 'no change'. The remainder of respondents opted for independent prescribing in some form. Option 1, independent prescribing for any condition from a full formulary, was the preferred option for 84% of all respondents. The remaining 15% preferred one of the other options, with a limited formulary, limited conditions, or both.

Option 1, independent prescribing for any condition from a full formulary, was the preferred option for NHS organisations, 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

¹⁰ Department of Health(2009), *Allied Health professions prescribing and medicines supply mechanisms scoping project report*, London www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103948

¹¹ Department of Health (2010), *Engagement exercise to seek views on possibilities for introducing independent prescribing responsibilities for physiotherapists and podiatrists*, London www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119164

¹² Department of Health (2011), *Proposals to introduce independent prescribing by podiatrists*, http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_129981

this option. Some respondents commented on the impracticalities of a specified formulary and of a limited list of conditions for podiatry. Other comments considered the importance of providing good governance, ensuring safe prescribing and the flexibility offered by option 1 within the individual practitioner's scope of practice and competence.

Option 2, independent prescribing for specified conditions from a specified formulary, was generally supported by the medical bodies, but only 8% of all respondents preferred this option. 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 to provide good communication of their prescribing to GPs and other clinicians.

Option 3, independent prescribing for any condition from a specified formulary, was the least popular of the options to introduce independent prescribing, with only 37 respondents selecting it. 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.

Option 4, independent prescribing for specified conditions from a full formulary, 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 summary of responses to the consultation, that this impact assessment is published alongside, provides a more detailed analysis of themes emerging from responses to the consultation.

One-in one-out

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

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

Specific Impact Tests

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

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

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

Social Impacts: The impact on health and well-being is discussed within this impact assessment, under the 'Wider impacts' section. With regards to the impact on human rights, no human rights articles will be impinged as a result of the policy and hence no human rights impact assessment was undertaken. Likewise the policy will not affect the workings of the courts, tribunals, prisons, the legal aid budget or the prosecuting bodies and judiciary. No justice impact assessment was undertaken because of this. The policy will make independent prescribing an option for those who meet the eligibility criteria, whether they be in a rural or urban setting. Given that podiatrists are practising throughout England there is no bias in its implementation and hence no rural proofing impact test undertaken.

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

Risk Assessment

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

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

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

Podiatrists may currently prescribe as supplementary prescribers and the progression to independent prescriber status is an addition to that responsibility. Enabling podiatrists to prescribe any licensed medicine for any condition subject to clinical competence will not be at the expense of endangering public health. Indeed no serious incidents or case law relating to AHP medicines use have been reported to date. Podiatrists will only be able to practise as independent prescribers once they have successfully completed the relevant educational programmes and have their registration annotated by their regulatory body. In order to maintain annotation, podiatrist independent prescribers will need to demonstrate that they maintain their skills and knowledge in line with practice and only work within their areas of competence.

Enforcement and sanctions

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

Background information on costs and benefits of independent prescribing for podiatry

Podiatrists

There are 12,536 podiatrists in the UK registered with the Health Professions Council (HPC)¹³. The Society of Chiropractic and Podiatry (SCP) has 8,350¹⁴ podiatrists in the UK registered as 'UK Practising Members' as of May 2011, of which the HPC has a count of 139 as supplementary prescribers¹⁵.

Projected number of podiatry patients requiring a prescription

It is estimated that 61% of patients who visit a podiatrist for the first time each year require a prescription¹⁶. This results in an estimated 45,188 podiatry patients requiring a prescription in 2010. We will assume that this number remains constant over the 10 year period included in these calculations.

Supply of independent prescribing educational programmes available to podiatrists

Podiatrists are currently able to train as supplementary prescribers at the following 55 Higher Education Institutions (HEIs) in the UK, which run HPC-approved programmes¹⁷:

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

The University of Bolton, Leeds Metropolitan University and City University offer multi-professional programmes with 100, 50 and 40-60 places respectively per year. It can be assumed that supplementary prescribing programmes will progress to offer full independent prescribing programmes for podiatrists in line with the changes in the profession's regulations. It

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

¹⁴ Sourced through correspondence with the Society of Chiropractic and Podiatry

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

¹⁶ North West Non-medical Prescribing Audit data 2010 and 2011, sourced via correspondence

¹⁷ Health Professions Council, Register of approved programmes www.hpc-uk.org/education/programmes/register

is assumed that conversion programmes will be phased out after year 2. Full independent prescribing training courses are of duration 6 months. Should the proposals be implemented, podiatrists would be able to undertake full independent prescribing training from Autumn 2013. The benefits as a result of the full training programme will therefore not be realised until the financial year 2014-15, and this is reflected in the calculations.

These courses are multi-professional and so are attended by nurses, pharmacists, physiotherapists and podiatrists. Given that podiatry is 1/30th the size of nursing it is a moderate assumption that podiatrists will take up 3% of these multi-professional courses. However, if greater demand for training exists amongst podiatrists, they will be able to take up a higher proportion of places; there is no restriction on this. It is assumed that demand from podiatrists will be for around 5% of available places during the first three years.

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

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

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

Demand for independent prescribing educational programmes by podiatrists

Demand for podiatrist independent prescribing educational programmes will depend on the demand for a podiatrist who can independently prescribe in the geographical area, the cost of the educational programme, availability of educational programmes and availability of a designated medical practitioner to supervise the practical aspect of the programme. Based on a survey of current supplementary prescribing podiatrists, 95% said they would pursue the educational programme to convert to independent prescribing (132 supplementary prescribers). We estimate that 60% of those wanting to convert will do so in year 1 and 40% in year 2. That is, 79 will demand the conversion course in year 1 and 53 in year 2. Conversion courses are thought not to exist past year 2 given that podiatrists will no longer pursue supplementary prescribing when independent prescribing is available.

Demand for the full independent prescribing programme by those with no current prescribing qualifications is projected at 5%. This is based on a sample survey with responses from around

400 practising podiatrists¹⁸. These responses suggest that around 8% of the currently eligible workforce would take up independent prescribing in the short term (over the first 3 to 5 years). This equates to approximately 5% of all practising podiatrists. As further evidence, between 2% and 3% of the nursing profession have taken on independent prescribing¹⁹. The proportion is expected to be higher for podiatrists because they come into contact with patients who would benefit from them being able to independently prescribe on a daily basis. This is largely because they work in the community setting more frequently, unlike nurses who largely work within a hospital and therefore in close proximity to an independent prescribing doctor.

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

It is assumed that 5% of the existing workforce (452) will take up independent prescribing over the first 3 years. In addition, there will be more podiatrists becoming eligible for independent prescribing each year. It is assumed that 5% of these newly-eligible podiatrists will also take up independent prescribing each year. The number of newly-qualified podiatrists each year is used as a proxy for the number of those newly-eligible for independent prescribing. The average number of newly-qualified podiatrists is 270 per year, 5% of this figure being 14 per year taking on independent prescribing²⁰.

In 2010-11 there were 61,747 first new appointments with a podiatrist in the NHS in England²¹, with 3,870 podiatrists working in the same area²². This equates to an average of 16 new appointments per year for each NHS podiatrist in England. This proportion is assumed to apply to all podiatrists in the UK in these calculations and is used to estimate the number of appointments that would be available with an independently prescribing podiatrist each year.

The proportion of these appointments that require a prescription is estimated to be 61%²³. This figure is based on audit data from the AHP North West non-medical prescribing (NMP) network. This annual clinical audit demonstrates how NMP impacts on the delivery of patient care. The audit covers a number of NHS organisations across the North West region and includes consultations from several professions, including podiatrists.

As part of this audit, clinicians were asked what the impact of their consultation had been. Of the 584 responses from podiatrists and physiotherapists in 2011, responses included:

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

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

¹⁸ Sample survey results obtained via correspondence.

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

²⁰ Health Professions Council, *Numbers of newly-qualified chiropodists and podiatrists*, <http://www.hpc-uk.org/assets/documents/10002E53FR00757Numberofchiropodistspodiatristsregisteringeachyear.pdf>.

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

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

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

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

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

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

Costs and benefits of options

'Do nothing' option

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

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

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

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

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

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

For instance, 2% of those in the UK with Diabetes are likely to suffer foot ulcers; those who do are 24 times more likely to have a major amputation as a result and 50% of those suffering die within 5 years. The cost of ulcers alone, aside from amputation costs, is £256 million per year²⁴.

²⁴ Associate Parliamentary Limb Loss Group, Meeting Minutes October 2010 Annexe A, <http://www.apllg.eu/resources/Annexe+A+25+10+10.pdf>

Timely administration of appropriate antibiotics has been shown to reduce hospital admissions and the risk of limb-threatening infection in people with diabetes²⁵.

Health benefits can be calculated using an economic evaluation method called Quality Adjusted Life Years (QALYs). A QALY is used to calculate the quality *and* quantity of life changes as a result of a health intervention. In this case the intervention is the timely provision of prescriptions due to independently prescribing podiatrists, which prevents acute conditions becoming LTCs, (or exacerbation of an existing LTC) rather than the patient having to wait to access the prescription from their GP.

This is projected to save £455,040 in year 1, £1,605,990 in year 2 and £27,550,350 over 10 years. Please see benefits section a) in Annex 2 for calculations of these figures (present value).

If this risk of developing a LTC was 1% rather than 3%, the saving would be £9,183,450 over 10 years (present value). If this risk was 5%, the saving would be £45,917,249 over 10 years (present value).

b) Reduction in GP requirements

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

bi) GP appointment → podiatry appointment → attendance at GP practice (in some cases for a GP appointment)
(or if self referral: podiatry appointment → GP)

bii) GP appointment → podiatry appointment
(or if self-referral: podiatry appointment)

Five minutes of a GP's time costs a GP surgery £10²⁶. The time saved for GPs would result in an estimated saving to GP surgeries in the UK of £7,772 in year 1, £26,900 in year 2 and £424,985 over the first 10 years (present value). Please see benefits section b) in Annex 2 for the calculation of these figures. This is not expected to be cash-releasing; it will permit alternative uses of GP time.

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

It has been shown that independent prescribing for podiatrists will shorten the patient's care pathway as they will no longer be required to attend a GP practice to access a prescription suggested by the podiatrist.

A moderate assumption for a patient's time requirement for attending a GP practice is 45 minutes, which includes travel, waiting and (in some cases) attending an appointment. The average hourly wage in the UK is £11.20²⁷. The 45 minutes therefore costs the patient £8.40.

²⁵ Department of Health(2009), *Allied Health professions prescribing and medicines supply mechanisms scoping project report*, London www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103948

²⁶ Personal Social Services Research Unit *Unit Costs of Health and Social Care 2010*, II Community-based staff, 10. Nurses and doctors , <http://www.pssru.ac.uk/uc/uc2010contents.htm>

²⁷ Office for National Statistics, *Annual Survey of Hours and Earnings*, 2011 Provisional results, Table 1.5a, median earnings for all employees, <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-235202>

This saving will only apply to those patients who are currently in employment. The proportion of podiatry patients currently in employment is estimated to be 58%²⁸.

This is projected to save £3,757 in year 1, £13,457 in year 2 and £205,409 over the first 10 years (present value). Please see benefits section c) in Annex 2 for the calculation of these figures.

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

d) Reduced prescriptions required due to tailored treatment

Podiatry appointments last approximately 30 minutes compared to an average 11-minute GP appointment. This provides more time with the clinician and therefore more tailored and comprehensive treatment of the patient's condition. There is an estimated 14% reduction in the number of required prescriptions because of this²⁹. This will be a saving for patients who fund their own prescription charges in England, or a saving to the Government in the case of the devolved administrations and for those patients in England who are on state benefits (for whom the Government subsidises prescription charges).

Accessing a prescription in England costs the patient £7.65. In the other countries of the UK, there is no such standard prescription charge, but there is still a cost to the Government associated with each prescription. The cost per prescription item in Scotland is £10.93³⁰, in Wales is £8.43³¹ and in Northern Ireland is £12.23³². For these calculations the value of £7.65 is used for the whole of the UK as a conservative estimate. The projected saving is £826 in year 1, £2,858 in year 2 and £45,155 over 10 years (present value). Please see benefits section d) in Annex 2 for details of these calculations.

Non-monetised benefits

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

Summary of Benefits

Independent prescribing for podiatrists would offer patients more accessible, timely, tailored and therefore potentially more effective treatment. It would reduce the burden on GPs' time and empower the podiatrist to treat the patient in the most effective way. This would ultimately improve the patient's experience of healthcare and improve their health. Please see Annex 2 for the 10 year financial projection of the benefits of introducing independent prescribing for podiatrists.

²⁸ Office for National Statistics, *Labour Market Statistics*, February 2012, <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-222474>

²⁹ Department of Health (2008), *Self-referral pilots to musculoskeletal physiotherapy and the implication for improving access to other AHP services*, London www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089516

³⁰ ISD Scotland (NHS National Services Scotland), *Prescribing and Medicines: Prescription Cost Analysis*, 2010-11, Table 2, <http://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Publications/2011-06-28/2011-06-28-PrescribingCosts-Report.pdf>

³¹ Welsh Government, *Prescriptions Dispensed in the Community, 2000-2010 and Prescription Cost Analysis Data*, <http://wales.gov.uk/topics/statistics/headlines/health2011/1103301/?lang=en>

³² Northern Ireland, Department of Health, Social Services and Public Safety, *Counts & Cost of Prescriptions*, 1990-2010, <http://www.dhsspsni.gov.uk/pas-facts-figures>

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

Cost of educational programmes for independent prescribing

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

a) Conversion programme to train from supplementary prescriber to independent prescriber
A conversion course costs on average £600. A survey of current supplementary prescribers showed that 95% would convert to independent prescribing. It is assumed these podiatrists will convert within the first 2 years of independent prescribing becoming available: 60% in year 1 = 79 and 40% in year 2 = 53.

Total cost of conversion courses = £78,125 (present value)

b) Full independent prescribing programme

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

Cost of full training programmes in year 1 = £188,750 (present value)

Cost of full training programmes over 10 year period = £646,040 (present value)

b) Cost of supervision by Designated Medical Practitioners

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

Cost of GP's time: Cost per hour of GMS activity = £121³³

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

Total DMP supervision costs in year 1 = £333,960 (present value)

Total DMP supervision costs over 10 year period = £939,502 (present value)

Non-monetised costs

c) time commitment required away from work for training

d) complexities of governance of the professions

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

Net benefit of Option 1: Independent prescribing for all conditions and full formulary

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

In year 1, the benefits from the full independent prescribing courses are yet to be realised. This is because the full independent prescribing courses will only become available to podiatrists partway through year 1 and the course is of duration 6 months. Therefore there is a net projected cost of £102,716 in year 1. During year 2, there is a net benefit of £1,149,467.

10 Year Period: £28,225,898 (benefit) - £1,663,667 (cost) = £26,562,231 (net present value)

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

³³ Personal Social Services Research Unit *Unit Costs of Health and Social Care 2010*, II Community-based staff, 10. Nurses and doctors , <http://www.pssru.ac.uk/uc/uc2010contents.htm>

Net benefits with the assumption of 1% risk of an acute condition becoming a LTC:
10 Year Period: £9,858,998 (benefit) - £1,663,667 (cost) = £8,195,331 (net present value)

Net benefits with the assumption of 5% risk of an acute condition becoming a LTC:
10 Year Period: £46,592,798 (benefit) - £1,663,667 (cost) = £44,929,131 (net present value)

Wider impacts

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

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

Training programmes are commissioned locally; existing programmes are multidisciplinary³⁴ and enable practitioners to access a programme leading to accreditation as independent prescribers – although currently podiatrists are only assessed as supplementary prescribers. This cost is already identified and is currently funded by the Strategic Health Authorities (SHAs). The cost per head of a non-medical educational programme is £730 in the NHS and £1500 for independent clinicians in the North West. There are also indirect costs associated with the time needed to attend prescribing training courses, which are met locally, as well as the supervising medical practitioner's time.

Podiatrists who have already successfully completed a supplementary prescribing programme and are annotated as a supplementary prescriber on the podiatry HPC register will be able to undertake a conversion programme to become an independent prescriber. The cost of a conversion programme is between £350 and £850. This is an identified 'new' cost but is likely to be time limited and only relevant to existing supplementary prescribers undertaking the conversion programme (a poll indicated that 96% of existing supplementary prescribers would convert to independent prescribers). 'New entrants' into the training programme would undertake the existing training programme where the costs are already met by local education commissioners.

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

- A general acceptance that nurse independent prescribing has shifted some prescribing practice from doctors to nurses with no overall increase in prescribing costs.
- Indications that further extending independent prescribing to podiatrists may reduce the overall number of prescriptions written. For example, through preventative foot healthcare and health promotion, treatment and rehabilitation using physical treatments and the use of corrective foot devices to help relieve painful foot conditions and the use of pain management medication, particularly for patients with diabetes, rheumatoid and osteo arthritis. The early intervention treatment of foot infections and other disorders of the skin, nail, soft tissue and connective tissues that could prevent leading to more serious or chronic foot problems.

³⁴ Existing multi disciplinary programmes for AHPs, nurses and pharmacists

Impact on small business: Implementation is voluntary; healthcare organisations would identify the requirements and budget for an independent prescribing role before deciding to embark on the training of podiatrists to become independent prescribers. A differential is found in the North West where supplementary prescribing courses cost a clinician from a NHS setting £730 as compared to £1500 for a private independent clinician (these prices are based on bulk buying courses from HEIs).

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

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

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

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

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

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

Patients attending hospital outpatient services in which part or most of their care is allied health professional-led, would need to see fewer individual professionals per visit. Podiatrists working at specialist or consultant level in diabetic or vascular foot care are expert in evidence-based delivery of antibiotic treatment of ulcers in the community. With a growing diabetic population in the UK³⁵ and a high rate of amputations in this population, effective frontline care in the community is essential in order to treat disease and prevent ill health. Extending access to medicines to traditionally hard-to-reach populations through enhanced podiatry services has the potential to reduce health inequalities. For example older people, disabled, traveller and ethnic minority groups are likely to benefit from enhanced, more accessible and responsive services being offered closer to home. Introducing independent prescribing by podiatrists has potential to improve access to medicines for patients in rural areas.

There is some evidence³⁶ that podiatrists treating certain categories of patients rather than GP centred care will reduce the number of prescriptions required as podiatrists are often able to explore a wider variety of treatment options than a GP. With independent prescribing status, the podiatrist can review the patient's existing medication and where physical treatment is appropriate for alleviating conditions, may discuss with the GP the option for reducing the need for some medication³⁷.

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

Autonomy, accountability and democratic legitimacy: The '*Liberating the NHS*' white paper is about empowering clinicians to serve their local population and one of the most significant of the proposed changes is the devolving of power and responsibility for commissioning. It is crucial that GPs make commissioning decisions that are fully informed by a wide range of clinicians working across all sectors including NHS, local authority, voluntary and private sectors. Dame Carol Black stated in her review that: "*GPs often feel ill-equipped to offer advice to patients on remaining in or returning to work*" (key challenge 5)³⁸ In contrast, podiatrists play key roles within innovative rehabilitation schemes and apply a bio-psychosocial and self-directed approach to work injury rehabilitation. Increasing the flexibility with which podiatrists prescribe and supply medicines as part of this has the potential to improve treatment effectiveness and thereby improve the health of the workforce.

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

³⁵ Masso-Gonzalez E., Johansson S., Wallander M. and Rodruquez L. (2009) Trends in the prevalence and incidence of diabetes in the UK: 1996-2005, *Journal of Epidemiology and Community Health*, 63, 332-6

³⁶ Department of Health (2008), *Self-referral pilots to musculoskeletal physiotherapy and the implications for improving access to other AHP services*, London www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089516

³⁷ Greenhalgh S. (2008), Bolton NHS Musculoskeletal Service. Unpublished audit data.

³⁸ Black C. (2008), *Dame Carol Black's Review of the health of Britain's working age population: Working for a healthier tomorrow*, London www.workingforhealth.gov.uk/Carol-Blacks-Review/

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

Existing processes may limit some podiatrist services from offering a range of prescribing or medicines supply and administration to best meet patient's needs. Problems reported by podiatrists highlight issues such as requiring numerous PGDs to manage a patient's condition or the availability of a medical practitioner to agree a clinical management plan. Doctor availability provides one of the greatest challenges to successful implementation of supplementary prescribing as many patients do not regularly access GP services and many podiatrists provide services in settings in which a doctor is not present. Similar difficulties are cited in the nursing literature³⁹. Other problems reported by podiatrists and reflected in the literature include uncertainty regarding who the independent medical prescriber should be when patients have complex issues and are under the care of more than one doctor⁴⁰ and difficulties when timeframes of care are short, such as short stays in hospital or one-off outpatient appointments⁴¹.

Value for Money: In the 2009 *Allied health professions prescribing and medicines supply mechanisms scoping project report*⁴² several value for money benefits are identified, in addition to patient and clinical benefits, which contributes robust evidence that the long term benefits of introducing independent prescribing by podiatrists will significantly outweigh initial start up and maintenance costs (primarily training costs).

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

- podiatrists can either offer enhanced comprehensive care by prescribing⁴³
- or supply and administering of medicines via mechanisms such as patient group directions and exemptions
- by offering this more comprehensive service, they make greater choice available to patients and commissioners of services, contributing to the creation of flexible system-wide values
- there is reduced duplication of care, as a patient does not have to see another professional, or another service, in order to receive the required prescription(s) for medicines
- the podiatry service often has a lower or competitive unit cost than an alternative provider as they are able to work in a flexible range of settings including the patient's home, as compared to secondary care
- the cost to the patient in both time and monetary cost is reduced, for example because they could take less time off work, reduced number of appointments and reduced travel time and cost

In some cases, the cost saving per case may be substantial for example, when podiatrists perform nail or foot surgery in a community setting. In other cases, the payment-by-results unit cost may be unchanged but improved service efficiency adds to overall value for money.

³⁹ Courtenay M. and Carey N. (2008), Nurse independent prescribing and nurse supplementary prescribing practice: national survey. *Journal of Advanced Nursing*, 61(3), 291–9

⁴⁰ Courtenay M., Carey N. and Burke J. (2007), Independent extended and supplementary prescribing practice: a national questionnaire survey. *International Journal of Nursing Studies*, 44(7), 1093–101

⁴¹ Stenner K. and Courtenay M. (2008), The role of inter-professional relationships and support for nurse prescribing in acute and chronic pain. *Journal of Advanced Nursing*, 63(3), 276–83

⁴² Department of Health(2009), *Allied Health professions prescribing and medicines supply mechanisms scoping project report*, London www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103948

⁴³ Prescribed medicines cannot be supplied by the prescriber, they must be supplied by a separate dispenser

Currently, podiatrists are only able to add a proportion of the increased value of which they are capable. Further productivity savings could be made if podiatrists were able to prescribe medicines with greater flexibility. Independent prescribing could enable greater improvements in productivity than can be achieved through supplementary prescribing as illustrated in the following instances:

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

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

Some patients' medication needs could be met by the podiatrist who is treating their condition in the community, without the need for additional GP or secondary care visits or appointments. This would apply to community podiatry services and specialist podiatry-led musculoskeletal services. The North West non-medical prescribing audit showed that, over the 2010 and 2011 audits, 61% of the patients visiting a podiatrist required a prescription⁴⁴ for their condition, which suggests that there is potential for large reductions in GP time and appointments in this population. While patients would still have the option of visiting their GP, many would not need to if their podiatrist could prescribe independently.

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

It is generally accepted that nurse prescribing has shifted some prescribing practice from doctors to nurses, with no overall increase in prescribing costs. There are some early indications that further extending prescribing to podiatrists may reduce the overall number of prescriptions written. For example, a prescribing podiatrist treating a patient with diabetes related foot problems or rheumatoid or osteoarthritic pain will have many different treatment modalities at their disposal; physical treatment for conditions such as functional foot and gait problems including the use of foot corrective devices; physical treatment of dermatological conditions such as foot ulcers, fungal and viral infections and wounds; and foot surgery for problems such as bunions and hammer toes. It follows that they may need to institute pharmaceutical treatment with less frequency than other professionals who may not have the other modalities at their disposal.

Information from podiatrist-led specialist services suggests that prescribing podiatrists often use supplementary prescribing to assess existing medications and consult with the GP to reduce or stop medications where physical treatment is effective, with the result that they less frequently prescribed new preparations. An example of the benefits of prescribing by an allied health profession was Bolton Primary Care Trust's successful consultant physiotherapy-led musculoskeletal service (winner of the *Health Service Journal* award for improving access in 2007) illustrates this. Audit data for 405 patients indicates that while only 3% of patients needed new prescriptions, 49% required modification of their existing medicines regime. This comprised 11% who required modification of their existing dose or preparation to improve therapeutic effect, 37% who needed modification or removal to stop medicines misuse (including 2% to stop

⁴⁴ North West Non-medical Prescribing Audit data 2010 and 2011, sourced via correspondence with Louise Stuart, NHS Manchester and Christopher Joyce, Wirral Health Informatics Services

dangerous misuse) and 1% who needed the removal of medicines to improve care⁴⁵. Additional positive patient and cost benefit effects is assumed as non medical prescribing is extended to other professions including podiatry, as evidenced in the North West NMP audit.

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

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

Summary and preferred option with description of implementation plan

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

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

The introduction of independent prescribing by podiatrists would quickly allow existing care pathways and more effective, efficient and safe patient care. It would also future-proof healthcare organisations and businesses with a flexible frontline workforce that are capable of leading the development of innovative new care pathways for the benefit of patients. Option 1, independent prescribing by podiatrists from a full formulary for any condition, was the preferred option by respondents to the public consultation (84%).

⁴⁵ Greenhalgh S. (2008), Bolton NHS Musculoskeletal Service. Unpublished audit data.

Annexes

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

Annex 1: Post Implementation Review (PIR) Plan

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

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

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

N/A

Annex 2: Projection of costs and benefits for Option 1: Independent prescribing for any condition from a full formulary

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

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

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

There were 139 supplementary prescribing podiatrists in the UK in September 2011. As a result of a sample survey of podiatrist supplementary prescribers it is estimated that 95% (132) convert to independent prescribing in the UK. It is assumed they will convert over the first 2 years and then conversion programmes for podiatrists will no longer be available. It is assumed that sufficient places will be available on conversion courses to meet demand (with 60% converting in year 1 and 40% in year 2).

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

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Projected demand for conversion independent prescribing educational programmes												
Number of supplementary prescribing podiatrists converting to independent prescribing	0	79	53									

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

It is estimated that there are, on average, 16 first appointments per year per podiatrist in the UK. This is based on there being 61,747 first appointments with NHS podiatrists in England in 2010-11 and 3,870 podiatrists working in NHS England in 2010. This gives an average 16 first appointments with podiatrists in the NHS per year, which is assumed here to be true also in the private sector and in the other countries of the UK.

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

Additional first appointments available with an independently prescribing podiatrist = (number of supplementary prescribers converting to independent prescribing) x (average number of first appointments per podiatrist)	0	1,264	848	0	0	0	0	0	0	0	0	0
Projected number of appointments available with an independently prescribing podiatrist per year (as a result of conversion from SP)	0	1,264	2,112	2112	2112	2112	2112	2112	2112	2112	2112	2112

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

The duration of the full independent prescribing course is 6 months, and the first courses are likely to be available to podiatrists from September 2013. The benefits will therefore not be realised until year 2, and so a value of zero has been used for the resulting number of appointments in year 1 (as a result of the full training). Available places are projected based on 3% of places being taken by podiatrists. In reality, this will be flexible as the courses are multidisciplinary and able to accommodate more podiatrists if there is the demand.

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Supply of independent prescribing educational programmes												
Estimated increase in provision of independent prescribing educational programmes	0%	0%	10%	10%	10%	0%	0%	0%	0%	0%	0%	0%
Projected availability of places on independent prescribing education programmes per year	2,750	2,750	3,025	3,328	3,660	3,660	3,660	3,660	3,660	3,660	3,660	3,660
Projected number of places available to podiatrists on independent prescribing programmes per year (based on 3% uptake)	0	83	91	100	110	110	110	110	110	110	110	110

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

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

Courses are attended by several professions, including nursing. Given that nursing is 30 times the size of podiatry, the assumed availability of places for podiatrists is 3%. From year 4, this exceeds projected demand. In years 1 to 3 the demand can be met by more than the assumed 3% of places being taken by podiatrists.

Demand for independent prescribing educational programmes

It is assumed that 5% of podiatrists will take up independent prescribing (IP). Between 2 and 3% of nurses have undertaken IP, and for podiatrists this is likely to be higher due to the nature of their practice. There are currently 8,211 fully practising members of the Society of Chiropractic and Podiatry in the UK who are not already supplementary prescribers. It is assumed that 5% of these will train as independent prescribers over the first 3 years. In addition, it is assumed that 5% of all newly-eligible podiatrists will train each year (14 per year). The figure of 5% is supported by a sample survey of eligible podiatrists. This suggested 8% of those eligible would take up IP, equating to around 5% of all practising podiatrists. The high demand for places in years 1 to 3 can be met by education providers taking on a higher proportion of podiatrists (around 5% rather than 3% of places) in these multiprofessional courses.

Projected demand of independent prescribing educational programmes by podiatrists per year	0	151	151	150	14	14	14	14	14	14	14
Cumulative number of podiatrists completing the full independent prescribing training programme	0	151	302	452	466	480	494	508	522	536	550

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

Number of newly-qualified podiatrists each year, for the last 7 years: <http://www.hpc-uk.org/assets/documents/10002E53FR00757Numberofchiroprpodiatristsregisteringeachyear.pdf>
An average of these is taken and used as a proxy for the number of podiatrists who are newly eligible for IP training each year (270).

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

Projected number of first appointments available with an independently prescribing podiatrist per year (full training programme)	0	0	2,416	4,832	7,232	7,456	7,680	7,904	8,128	8,352	8,576
Total projected first appointments available with an independently prescribing podiatrist (sum for both types of training programme)	0	1,264	4,528	6,944	9,344	9,568	9,792	10,016	10,240	10,464	10,688

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

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

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

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

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Cost of conversion programmes = (cost of one conversion programme)x(number of conversion programmes undertaken each year)	£0	£47,400	£31,800									
Discount at 3.5%	£0	£47,400	£30,725									£78,125

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

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

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Estimated cost of full independent prescribing courses undertaken	£0	£188,750	£188,750	£187,500	£17,500	£17,500	£17,500	£17,500	£17,500	£17,500	£17,500	
Discounted at 3.5%	£0	£188,750	£182,367	£175,033	£15,784	£15,250	£14,735	£14,236	£13,755	£13,290	£12,840	£646,040

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

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

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

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Number of independent prescribing educational programmes undertaken each year (for years 1 and 2 this is the sum of both types of training programme)	0	230	204	150	14	14	14	14	14	14	14	
Total cost of DMP supervision for all podiatrists training as independent prescribers	£0	£333,960	£296,208	£217,800	£20,328	£20,328	£20,328	£20,328	£20,328	£20,328	£20,328	
Discounted at 3.5%	£0	£333,960	£286,191	£203,319	£18,335	£17,715	£17,116	£16,537	£15,978	£15,437	£14,915	£939,502
Total projected financial cost	£0	£570,110	£499,283	£378,352	£34,119	£32,965	£31,850	£30,773	£29,732	£28,727	£27,756	£1,663,667

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

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

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

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

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

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Estimated number of patients that would receive this health benefit as a result of IP for podiatrists (3% of total first appointments with an IP podiatrist)	0	38	136	208	280	287	294	300	307	314	321	
Resulting estimated financial health benefit = (financial benefit per patient)x(number of patients that independent prescribing reduces risk for)	£0	£455,040	£1,630,080	£2,499,840	£3,363,840	£3,444,480	£3,525,120	£3,605,760	£3,686,400	£3,767,040	£3,847,680	
Discounted at 1.5% per year	£0	£455,040	£1,605,990	£2,426,499	£3,216,897	£3,245,335	£3,272,229	£3,297,620	£3,321,545	£3,344,043	£3,365,151	£27,550,350

b) Reductions in GP requirements

Independent prescribing would save a visit to the GP for those requiring a prescription. Some patients would require a GP appointment but this would not be the case for all. As a conservative estimate, we have assumed that the GP would save 5 minutes of time per patient to assess the patient notes and issue the prescription.
 Number of first appointments with a podiatrist in the UK in a year = 74,078
 Calculated as number of first appointments with an NHS podiatrist in England in 2010-11, multiplied (using GP registered population data) to obtain a figure for the UK (and assumed to be the same each year thereafter)
 Number of podiatry appointments estimated to require a prescription = (number of first appointments with a podiatrist) x (proportion of appointments requiring a prescription) = 74,078 x 61% = 45,188
 5 minutes of GMS activity = £10.08

England figure obtained from: <http://www.hesonline.nhs.uk/Ease/servelet/ContentServer?siteID=1937&categoryID=895>
 61% obtained from NW NMP audit data, sourced via correspondence. Over two years of audit (2010 and 2011), 496 of the 807 podiatrist consultations required a prescription. Some audit details available at: <http://www.prescribingforsuccess.co.uk/ahpzone/>
 GMS activity cost: <http://www.pssru.ac.uk/uc/uc2010contents.htm>

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Number of appointments that require a prescription and are covered by independent prescribing podiatrists	0	771	2,762	4,236	5,700	5,836	5,973	6,110	6,246	6,383	6,520	
Projected financial savings to GP practices in the UK = (number of appointments requiring prescription and covered by independent prescribers) x (cost of GP time to issue prescription)	£0	£7,772	£27,842	£42,697	£57,454	£58,832	£60,209	£61,586	£62,964	£64,341	£65,718	
Discounted at 3.5% per year	£0	£7,772	£26,900	£39,658	£51,821	£51,268	£50,694	£50,101	£49,489	£48,861	£48,220	£424,965

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

For those patients who work, there will be a saving for not having to attend the GP practice to access a prescription. A moderate assumption is that a typical visit to the GP to access a prescription takes 45 minutes. This results in loss of earnings of £9.40 per patient, given the average hourly wage in the UK of £11.20.
 This saving is applied here to the proportion of resident UK population who are in employment: 29,129,000/50,339,000=0.58
 There will be additional savings (not included in calculations) from reduced travel costs for these patients.

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

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Number of appointments (that require a prescription and are covered by an independently prescribing podiatrist) that are taken by patients who are employed	0	447	1,602	2,457	3,306	3,385	3,464	3,544	3,623	3,702	3,781	
Projected saving to patients for not having to attend GP practice to access their prescription per year = (average earnings lost from attending GP practice) x (number of appointments taken by patients who are employed)	£0	£3,757	£13,457	£20,637	£27,770	£28,435	£29,101	£29,767	£30,432	£31,098	£31,764	
Discounted at 3.5% per year	£0	£3,757	£13,002	£19,265	£25,047	£24,780	£24,502	£24,215	£23,920	£23,616	£23,306	£205,409

d) Reduced prescriptions required due to more specialist treatment from podiatrist

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

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

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Estimated number of first appointments with a podiatrist each year that require a prescription	0	771	2,762	4,236	5,700	5,836	5,973	6,110	6,246	6,383	6,520	
Projected reduction in number of prescriptions required	0	108	387	593	798	817	836	855	874	894	913	
Projected financial saving = (cost of a prescription) x (projected reduction in prescriptions required)	£0	£826	£2,958	£4,537	£6,105	£6,251	£6,397	£6,544	£6,690	£6,836	£6,983	
Discounted at 3.5% per year	£0	£826	£2,858	£4,235	£5,506	£5,447	£5,386	£5,323	£5,258	£5,192	£5,123	£45,155
Total projected financial saving	£0	£467,394	£1,648,750	£2,489,857	£3,299,270	£3,326,830	£3,352,812	£3,377,259	£3,400,212	£3,421,712	£3,441,800	£28,225,898

NW non-medical prescribing audit data 2010 and 2011: obtained via correspondence. Over two years of audit (2010 and 2011), 496 of the 807 podiatrist consultations required a prescription (61%).
 Some audit details available at: <http://www.prescribingforsuccess.co.uk/ahpzone/>

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

Year	2012-13 (Year 0)	2013-14 (Year 1)	2014-15 (Year 2)	2015-16 (Year 3)	2016-17 (Year 4)	2017-18 (Year 5)	2018-19 (Year 6)	2019-20 (Year 7)	2020-21 (Year 8)	2021-22 (Year 9)	2022-23 (Year 10)	Total
Annual Cost	£0	£570,110	£499,283	£378,352	£34,119	£32,965	£31,850	£30,773	£29,732	£28,727	£27,756	£1,663,667
Annual Benefit	£0	£467,394	£1,648,750	£2,489,857	£3,299,270	£3,326,830	£3,352,812	£3,377,259	£3,400,212	£3,421,712	£3,441,800	£28,225,898
Projected 10 year net benefit:											£26,562,231	

Annex 3: References

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