Title:	Impact Assessment (IA)
PROPOSALS TO INTRODUCE INDEPENDENT PRESCRIBING BY PODIATRISTS	**IA No:** 1019
Lead department or agency: Department of Health	**Date: 27**/07/2011
Other departments or agencies: MHRA, Commission on Human Medicines, Health Professions Council	**Stage:** Consultation
	Source of intervention: Domestic
	Type of measure: Other
	Contact for enquiries: Jo Wilkinson 0113 25 46073 Jo.Wilkinson1@dh.gsi.gov.uk

Summary: Intervention and Options

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. These mechanisms have 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 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 independent prescribing responsibilities is about making the best use of professional skills and 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, improving their experience, reducing the risk of an acute condition becoming a long term condition, reducing the patient's care pathway, reducing requirements on GPs, and reducing unscheduled 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)

The following are the considered options, shown in order of preference as expressed from the engagement exercise. The preferred option is Option 1, which received 72% support from the engagement exercise. As a comparison, the next preferred option, Option 2, received 7% support. A sixth option 'Combination of other prescribing options' (2%) is not being included for the full public consultation.

Option 1 - Independent prescribing for any condition from a full formulary 72%

Option 2 - Independent prescribing for specified conditions from a specified formulary 7%

Option 3 - Independent prescribing for any condition from a specified formulary 6%

Option 4 - Independent prescribing for specified conditions from a full formulary 4%

Option 5 - No change 2%

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 7/2017 **What is the basis for this review?** PIR. **If applicable, set sunset clause date:** Month/Year	
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	Yes

SELECT SIGNATORY Sign-off For consultation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible SELECT SIGNATORY: ..... Date: .....

Summary: Analysis and Evidence

Policy Option 1

Description:

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

Price Base Year 2010	PV Base Year 2010	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £6.5m	**High:** £33.3m	**Best Estimate: £19.9m**

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		£0.078m	**£0.783m**

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 or 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'

-Availability and cost of Designated Medical Practitioners (DMPs), who supervise the practical part of the educational programme, is not monetised as experience with current independent/supplementary prescribing programmes is that no cost is incurred in respect of their time

-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	£0		£0.724m	**£7.236m**
High	£0		£3.410m	**£34.099m**
Best Estimate	£0		£2.007m	**£20.668m**

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 appointments solely to prescribe medicines

-reduced patient's time away from work to follow up GP appointment 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 **Discount rate (%)** 3.5

-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

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	No	NA

Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?			01/07/2012		
Which organisation(s) will enforce the policy?			Department of Health, MHRA		
What is the annual change in enforcement cost (£m)?			0		
Does enforcement comply with Hampton principles?			Yes		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** 0	**Non-traded:** 0	
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			**Costs:** 0	**Benefits:** 0	
Distribution of annual cost (%) by organisation size (excl. Transition) (Constant Price)	**Micro**	**< 20**	**Small**	**Medium**	**Large**
Are any of these organisations exempt?	No	No	No	No	No

Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on…?	**Impact**	**Page ref within IA**
Statutory equality duties[1] Statutory Equality Duties Impact Test guidance	Yes	
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	31
Small firms Small Firms Impact Test guidance	No	27
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	16
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	16
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	No	16
Human rights Human Rights Impact Test guidance	No	16
Justice system Justice Impact Test guidance	No	16
Rural proofing Rural Proofing Impact Test guidance	No	16
Sustainable development Sustainable Development Impact Test guidance	No	16

[1] Public bodies including Whitehall departments are required to consider the impact of their policies and measures on race, disability and gender. It is intended to extend this consideration requirement under the Equality Act 2010 to cover age, sexual orientation, religion or belief and gender reassignment from April 2011 (to Great Britain only). The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Summary: Analysis and Evidence

Policy Option 2

Description:

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

Price Base Year 2010	PV Base Year 2010	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £4.3m	**High:** £23.1m	**Best Estimate: £13.7m**

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	£0		£0.078m	**£0.783m**

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 or 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'

-Outlining and revising the most appropriate specified conditions and specified formulary

-Doctors supervisory time is not monetised at present for current non-medical prescribing programmes

-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	£0		£0.507m	**£5.065m**
High	£0		£2.387m	**£23.869m**
Best Estimate	£0		£1.405m	**£14.468m**

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

Benefits under Option 2 will be a smaller proportion than under Option 1. A working assumption is that they are 70% of those under Option 1 due to independent prescribing being limited to both a specified formulary and to specified conditions. These pose restrictions on service redesign, inhibiting the clinicians ability to provide a fully flexible and accessible service to the patient.

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 **Discount rate (%)** 3.5

-choosing and revising the most appropriate list of specified conditions and specified formulary
-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

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	No	NA

Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?			01/07/2012		
Which organisation(s) will enforce the policy?			Department of Health, MHRA		
What is the annual change in enforcement cost (£m)?			0		
Does enforcement comply with Hampton principles?			Yes		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** 0	**Non-traded:** 0	
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			**Costs:** 0	**Benefits:** 0	
Distribution of annual cost (%) by organisation size (excl. Transition) (Constant Price)	**Micro**	**< 20**	**Small**	**Medium**	**Large**
Are any of these organisations exempt?	No	No	No	No	No

Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on…?	**Impact**	**Page ref within IA**
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Economic impacts		
Competition Competition Assessment Impact Test guidance	No	31
Small firms Small Firms Impact Test guidance	No	27
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	16
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	16
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	No	16
Human rights Human Rights Impact Test guidance	No	16
Justice system Justice Impact Test guidance	No	16
Rural proofing Rural Proofing Impact Test guidance	No	16
Sustainable development Sustainable Development Impact Test guidance	No	16

[1] Public bodies including Whitehall departments are required to consider the impact of their policies and measures on race, disability and gender. It is intended to extend this consideration requirement under the Equality Act 2010 to cover age, sexual orientation, religion or belief and gender reassignment from April 2011 (to Great Britain only). The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Summary: Analysis and Evidence

Policy Option 3

Description:

Option 3: Independent prescribing for any condition from a specified formulary

Price Base Year 2010	PV Base Year 2010	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £5.0m	**High:** £26.5m	**Best Estimate: £15.8m**

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	£0		£0.078m	**£0.783m**

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 or 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'

-Outlining and revising the most appropriate specified conditions and specified formulary

-Doctors supervisory time is not monetised at present for current non-medical prescribing programmes

-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	£0		£0.579m	**£5.789m**
High	£0		£2.728m	**£27.279m**
Best Estimate	£0		£1.606m	**£16.534m**

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

Benefits under Option 3 will be a smaller proportion than under Option 1. A working assumption is that they are 80% of those under Option 1 due to independent prescribing being limited to a specified formulary. This poses restrictions on service redesign, inhibiting the clinicians ability to provide a fully flexible and accessible service to the patient.

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 **Discount rate (%)** 3.5

-choosing and revising the most appropriate list of specified formulary
-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

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	No	NA

Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?			01/07/2012		
Which organisation(s) will enforce the policy?			Department of Health, MHRA		
What is the annual change in enforcement cost (£m)?			0		
Does enforcement comply with Hampton principles?			Yes		
Does implementation go beyond minimum EU requirements?			No		
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** 0	**Non-traded:** 0	
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			**Costs:** 0	**Benefits:** 0	
Distribution of annual cost (%) by organisation size (excl. Transition) (Constant Price)	**Micro**	**< 20**	**Small**	**Medium**	**Large**
Are any of these organisations exempt?	No	No	No	No	No

Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

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Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	16
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	16
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	No	16
Human rights Human Rights Impact Test guidance	No	16
Justice system Justice Impact Test guidance	No	16
Rural proofing Rural Proofing Impact Test guidance	No	16
Sustainable development Sustainable Development Impact Test guidance	No	16

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Summary: Analysis and Evidence

Policy Option 4

Description:

Option 4: Independent prescribing for specified conditions from a full formulary

Price Base Year 2010	PV Base Year 2010	Time Period Years 2010	Net Benefit (Present Value (PV)) (£m)		
			Low: £5.0m	**High:** £26.5m	**Best Estimate: £15.8m**

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	£0		£0.078m	**£0.783m**

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 or 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'

-Outlining and revising the most appropriate specified conditions and specified formulary

-Doctors supervisory time is not monetised at present for current non-medical prescribing programmes

-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	£0		£0.597m	**£5.789m**
High	£0		£2.728m	**£27.279m**
Best Estimate	£0		£1.606m	**£16.534m**

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

Benefits under Option 4 will be a smaller proportion than under Option 1. A working assumption is that they are 80% of those under Option 1 due to independent prescribing being limited to a specified formulary. This poses restrictions on service redesign, inhibiting the clinicians ability to provide a fully flexible and accessible service to the patient

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 **Discount rate (%)** 3.5

-choosing and revising the most appropriate list of specified conditions
-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

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	No	NA

Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?			01/07/2012		
Which organisation(s) will enforce the policy?			Department of Health, MHRA		
What is the annual change in enforcement cost (£m)?			0		
Does enforcement comply with Hampton principles?			Yes		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** 0	**Non-traded:** 0	
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			**Costs:** 0	**Benefits:** 0	
Distribution of annual cost (%) by organisation size (excl. Transition) (Constant Price)	**Micro**	**< 20**	**Small**	**Medium**	**Large**
Are any of these organisations exempt?	No	No	No	No	No

Specific Impact Tests: Checklist

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Evidence Base (for summary sheets) – Notes

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

References

Include the links to relevant legislation and publications, such as public impact assessments of earlier stages (e.g. Consultation, Final, Enactment) and those of the matching IN or OUTs measures.

No.	Legislation or publication
1	Please see Annex 3 for all references
2	
3	
4	

+ Add another row

Evidence Base

Ensure that the information in this section provides clear evidence of the information provided in the summary pages of this form (recommended maximum of 30 pages). Complete the **Annual profile of monetised costs and benefits** (transition and recurring) below over the life of the preferred policy (use the spreadsheet attached if the period is longer than 10 years).

The spreadsheet also contains an emission changes table that you will need to fill in if your measure has an impact on greenhouse gas emissions.

Annual profile of monetised costs and benefits* - (£m) constant prices

	Y_0	Y_1	Y_2	Y_3	Y_4	Y_5	Y_6	Y_7	Y_8	Y_9
Transition costs	0	0	0	0	0	0	0	0	0	0
Annual recurring cost	0.101	0.093	0.076	0.081	0.078	0.076	0.073	0.071	0.068	0.066
Total annual costs	0.101	0.093	0.076	0.081	0.078	0.076	0.073	0.071	0.068	0.066
Transition benefits	0	0	0	0	0	0	0	0	0	0
Annual recurring benefits	0.707	1.577	1.044	1.428	1.796	2.153	2.499	2.834	3.159	3.473
Total annual benefits	0.707	1.577	1.044	1.428	1.796	2.153	2.499	2.834	3.159	3.473

* For non-monetised benefits please see summary pages and main evidence base section

All Cost and Benefit Information and Summary Calculations – please see Annex 2

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. A Ministerial submission was made on 4 January 2011 seeking agreement to public consultation on these proposals, where Ministers agreed for the work to go forward and asked for formal agreement before going live on any consultation.

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 University[1] 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 Chiropodists and Podiatrists (SCP) and The Institute of Chiropodists 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.

Work is being completed to show how practice guidance and eligibility criteria would work should independent prescribing for podiatrists be implemented. The Society of Chiropodists and Podiatrists and The Institute of Chiropodists and Podiatrists have undertaken significant work and have drafted practice guidance for their members who wish to take on independent prescribing. Eligibility criteria for entrants on to the educational programme are being developed such as those proposed in the engagement exercise listed below, which are being revised following responses received from the engagement exercise:

- 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

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

- have an approved medical practitioner to supervise and assess their clinical training as a prescriber.

Policy context

The key themes in the white paper *Equity and Excellence: Liberating the NHS*[2], put patients and the public first, prioritises improving healthcare outcomes, autonomy, accountability, efficiency and democratic legitimacy and cutting bureaucracy. It aims 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 makes 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 emerging health policy builds 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] endorses an increasingly flexible, responsive and patient focused workforce and *Framing the contribution of Allied Health Professionals: Delivering High Quality Healthcare*[6] highlights 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.

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 shown for introducing independent prescribing. As a point of comparison only 2%

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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

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 may choose to 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 and 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 drug 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.

[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

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 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, can use some antibiotics to treat an 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 and the ongoing nature of the condition. Supplementary prescribing is not suited to one-off episodes of care, particularly as and when the podiatrist is assessing, diagnosing and independently managing the patient. When supplementary prescribing is attempted, the time taken for the agreement of the clinical management plan risks the worsening of infected wounds, leading to greater clinical risk, potentially avoidable hospital admission and possible amputation. Consequently, the supplementary prescriber must take alternative and potentially costly action, such as an A&E referral.

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 medicines[9], potentially reducing waste and improving outcomes for patients with existing disease. It also has the potential to help improve health and well-being through better long-term use of medicines.

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 Department of Health Non- Medical Prescribing Board accepted the recommendations from the report and from the Medicines and Healthcare products Regulatory Agency to do further work to take forward independent prescribing for podiatrists. Therefore the engagement exercises sought to gather information and views on possible changes to medicines legislation, which would enable appropriately trained podiatrists to prescribe independently.

Options were presented for comment and the following are presented in the order of preference as expressed by responses received from the engagement exercise.

Option 1: Independent prescribing for any condition from a full formulary (72%)
Option 2: Independent prescribing for specified conditions from a specified formulary (7%)
Option 3: Independent prescribing for any condition from a specified formulary (6%)
Option 4: Independent prescribing for specified conditions from a full formulary (4%)
Option 5: No change (i.e. maintain the status quo – supplementary prescribing) (2%)
Option 6: A combination of independent prescribing options above (2%) (option not included in the public consultation)

It is standard in any engagement exercise to include a 'do nothing' option. However this option does not necessarily imply that the status quo will continue. This baseline option needs to take into account changes that are likely to occur in the system without any intervention.

The response to the engagement exercise[11] was overwhelmingly positive. There were 177 responses, with 83% received from individuals and 17% from organisations. There was 91% support for extending independent prescribing by podiatrists, 2% were in favour of no change with the remaining 7% undecided or not selecting a preference.

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

[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

The were 11 questions that sought views on eligibility criteria, governance arrangements, controlled drugs, unlicensed drugs/off label medicines, mixing of medicines in addition to potential benefits, costs and the impact on equality.

There were a number of comments made in respect of the all the questions in the engagement exercise. These ranged from the benefits for patients to the training required to ensure competence. Overall, the engagement exercise has gathered significant information on the key issues and posed some further questions in respect of independent prescribing by podiatrists to inform a public consultation. A full summary of the results of the engagement exercise is attached to this impact assessment in Appendix I.

One-in one-out

The Government introduced the one-in one-out 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 it's 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 help to open new markets within healthcare.

Specific Impact Tests

Assessment of Impact on Equality: An AIE has been undertaken as part of this impact assessment and it is expected that more evidence is to be 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 within 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.

Podiatrists that choose to implement non-medical prescribing must identify clinical staff 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 prescribers from the outset and so the requirements for a conversion educational programme will be time limited.

The take up of independent prescribing will, in any case, be limited by local decision making. The decision to implement independent prescribing is a voluntary one, and will be bounded by an assessment of population need, specialist clinical areas and local commissioning arrangements.

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 professional capacity 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.

<u>Enforcement and sanctions</u>

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. As these proposals are voluntary, sanction will only apply where an organisation/individual had participated voluntarily and then 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 9,758 podiatrists in England registered with the Health Professions Council (HPC)[12]. The Society of Chiropody and Podiatry (SCP) has 6048[13] podiatrists in England registered as 'UK Practising Members' as of May 2011, of which the HPC has a count of 96 as supplementary prescribers[14].

Projected number of podiatry patients requiring a prescription

It is estimated that 33% of patients who visit a podiatrist for the first time each year require a prescription[15]. If we apply this proportion to podiatry, it results in an estimated 1,995 podiatry patients requiring a prescription in 2010. We will assume, for the purpose of calculations, that this number remains constant over the coming 10 years.

Supply of independent prescribing educational programmes available to podiatrists

Podiatrists are currently able to train as supplementary prescribers at the following Higher Education Institutions (HEIs), which run HPC approved programmes[16]:

Brighton University
Birmingham City University
Bournemouth University
City University
Keele University
Liverpool John Moore's University
Manchester Metropolitan University
Northumbria University
Sheffield Hallam University
Suffolk University
University of Bolton
University of Central Lancashire
University of Chester
University of Cumbria
University of Huddersfield
University of Hull
University of Salford
University of Worcester

The University of Bolton offers multi-professional programmes with 100 places across two intakes per year. It can be assumed that supplementary prescribing programmes, such as that offered at Bolton University, will progress to offer full independent prescribing programmes in line with the changes in the profession's regulations. It is assumed that conversion programmes will be phased out after year 2 and only independent prescribing programmes will continue to exist given that supplementary prescribing will no longer be an attractable option once independent prescribing is in place.

These courses are multi-professional and so are attended by nurses, pharmacists and podiatrists. Given that podiatry is 1/30th the size of nursing it is a moderate assumption that, at best, podiatrists will take up 3% of these multi-professional courses.

Table 1a): Projection of the supply of conversion independent prescribing educational programmes available to podiatrists who are converting from supplementary prescribing to independent prescribing

[12] Health Professions Council, *FR01148c England statistics March 2011*, www.hpc-uk.org/assets/documents/100033E5FR01148c EnglandstatisticsMarch2011.pdf

[13] Sourced through correspondence with the Society of Chiropody and Podiatry

[14] Sourced through correspondence with the Health Professions Council

[15] 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

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

Year	1	2	3	4	5	6	7	8	9	10
Projected availability of places on conversion independent prescribing education programmes per year	1800	1800								
Estimated percentage of places taken up by podiatrists	0.03	0.03								
Projected number of places on independent prescribing educational programmes taken up by podiatrists per year	55	37								

Given the estimated high demand for independent prescribing educational programmes it can be assumed that provision of the programmes will increase. Here it has been estimated that this will be an increase of 10% in year 2, 3 and 4.

Table 1b): Projection of the supply of full independent prescribing educational programmes available to podiatrists

Year	1	2	3	4	5	6	7	8	9	10
Estimated percentage increase in provision of independent prescribing educational programmes	0.0	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0
Projected availability of places on independent prescribing education programmes per year	1800	1980	2178	2396	2396	2396	2396	2396	2396	2396
Estimated percentage of places taken up by podiatrists	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03
Projected number of places on independent prescribing educational programmes taken up by podiatrists per year	54	59	65	72	72	72	72	72	72	72

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 physiotherapists, 96% said they will pursue the educational programme to convert to independent prescribing. A moderate assumption is to assume the same for podiatry. We estimate that 60% of those wanting to convert (96 supplementary prescribers) will convert in year 1 and 40% in year 2. That is, 55 will demand the conversion course in year 1 and 37 in year 2. Conversion courses are thought not to exist past year 2 given that podiatrists will no longer want to become a supplementary prescriber when independent prescribing is available.

Table 2a): Projection of demand of conversion independent prescribing educational programmes by podiatrists who are converting from supplementary prescribing to independent prescribing

Year	1	2	3	4	5	6	7	8	9	10
Projected number of supplementary prescribing podiatrists demanding conversion independent prescribing education programmes	55	37								

Demand for the full independent prescribing programme by those with no current prescribing qualifications is projected at 5%. This is based on the evidence that 2% of the nursing profession took on independent prescribing. It 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. Therefore an estimated 1,539 podiatrists are to demand full independent prescribing educational programmes in year 1.

Table 2b): Projection of demand of full independent prescribing educational programmes by podiatrists

Year	1	2	3	4	5	6	7	8	9	10
Number of fully practising podiatrists in England with no prescribing qualifications	5,952	5,839	5,660	5,409	5,087	4,692	4,226	3,688	3,078	2,396
Estimated proportion demanding independent prescribing educational programmes	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05
Projected number of podiatrists demand independent prescribing educational programmes	298	292	283	270	254	235	211	184	154	120

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

Table 3a: Projection of appointments available with podiatrists who can independently prescribe over the first 10 years as a result of converting from supplementary to independent prescribers (it is assumed that conversions will take place in the first 2 years)

Year	1	2	3	4	5	6	7	8	9	10
Average number of first appointments with a podiatrist per year	16	16								
Projected appointments available each year with an independently prescribing podiatrist	880	1,472								

Table 3b: Projection of appointments available with podiatrists who can independently prescribe over the first 10 years as a result of full independent prescribing programmes

Year	1	2	3	4	5	6	7	8	9	10
Average number of first appointments with a podiatrist per year	16	16	16	16	16	16	16	16	16	16
Resulting projection of appointments available each year with a podiatrist who can independently prescribe per year	864	1,814	2,860	4,010	5,160	6,310	7,460	8,610	9,760	10,910

Costs and benefits of options

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)
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 by 3%. An assumption is made because there is no evidence to what this figure is across different acute conditions. A range is therefore inserted here 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 foots ulcers and those who do are 24 times more likely to have a major amputation as a result of it and 50% of those suffering die within 5 years. The cost of ulcers alone, aside from amputation costs, is £256 million per year[17].

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

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 prescription due to independently prescribing podiatrists which prevents an acute condition becoming an LTC, which is more likely should the patient have to wait to access the prescription through a further GP appointment.

This is projected to save £627,840 in year 1 and £20,146,805 over 10 years. Please see Benefits 1a) and 1b) in Annex 2 for calculations of these figures.

If this risk were 1% then the saving would be £209,280 for year 1 and £6,715,602 over 10 years.
If this risk were 5% then the saving would be £1,046,400 for year 1 and £33,578,009 over 10 years.

b) Reduction in GP requirements
The introduction of independent prescribing will mean that patients are not required to visit a GP in order to access a prescription recommended by the podiatrist. The GP appointment that is no longer required will result in fewer requirements on the GP. The patient's pathway will therefore change from bi) to bii)

bi) GP appointment → podiatry appointment → GP appointment
(or if self referral: podiatry appointment → GP appointment)

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

One GP appointment costs a GP surgery £36[18]. The no longer required GP appointment will result in a financial saving to GP surgeries in England of £62,784 in year 1 and an estimated £418,482 over the first 10 years. Please see benefits 2a) and 2b) in Annex 2 for the calculation of these figures.

c) Reduced time away from work for patient to acquire prescription
It can be seen in part above how independent prescribing for podiatrists will shorten the patient's care pathway as they will no longer be required to attend a GP appointment to access a prescription suggested by the podiatrist.

A moderate assumption for a patient's time requirement for attending a GP appointment is 45 minutes, which includes travel, waiting and attending the appointment. The average hourly wage in England is £11.13[19]. The 45 minutes therefore costs the patient £8.35.

This is projected to save £14,558 in year 1 and £89,938 over the first 10 years. Please see benefits 1c) and 2c) in Annex 2 for the calculation of these figures.

d) Reduced prescriptions required due to tailored treatment
Podiatry appointments last approximately 40 minutes as compared to an average 11-minute GP appointment. It provides the patient with more time with the clinician and therefore more tailored and comprehensive treatment of their condition. There is an estimated 14% reduction in the number of required prescriptions because of this[20]. This will be a saving for the patient should they fund the prescription charge themselves or a saving to the government who subsidies prescription charges for those who are on state benefits.

[18] Page 163, Personal Social Services Research Unit www.pssru.ac.uk/pdf/uc/uc2010/uc2010_s10.pdf

[19] Office of National Statistics, *Labour Market Earnings*, http://www.statistics.gov.uk/cci/nugget.asp?id=167

[20] 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

Accessing a prescription in England costs the patient £7.40, which would result in a projected saving of £1,825 in year 1 and £12,434 over 10 years. Please see 1d) and 2d) in Annex 2 for details of how these calculations were made.

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)

Summary of Benefits

Podiatrists who can independently prescribe offer patients more accessible, timely, tailored and therefore potentially more effective treatment. It reduces the burden on GP's time and empowers the podiatrist to treat the patient in the most effective way. This ultimately improves the patient's experience of healthcare and improves their health. Please see Table 1 in Appendix 3 for the 10 year financial projection of the benefits of introducing independent prescribing for podiatrists.

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

a) Cost of educational programmes for independent prescribing

It can be seen above that demand for independent prescribing educational programmes is projected to outweigh supply of the educational programmes. The full independent prescribing educational programmes available are therefore expected to be fully attended. Conversion programmes are expected to remain in place for year 1 and 2 only, as once independent prescribing is introduced podiatrists will no longer take on supplementary prescribing as it does not offer the benefits that independent prescribing offers.

ai) 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 96% 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 = 92 and 40% in year 2 = 62.

aii) Full independent prescribing programme

A full independent prescribing educational programme costs on average £1,250. Due to demand outweighing supply of programmes, it is assumed all available programmes will be filled and are their provision expanded by 10% over years 2, 3 and 4.

Total training costs in year 1 = £100,500
Total training costs over 10 year period = £782,753

Non-monetised costs

b) availability and cost of Designated Medical Practitioners (DMPs), who supervise the practical part of the educational programme, is not monetised as experience with current independent/supplementary prescribing programmes is that no cost is incurred in respect of their time

c) cost of designated medical practitioners' time for supervising the practical aspect of the course
d) time commitment required away from work for training
e) complexities of governance of the professions

Net benefit of Option 1: Independent prescribing for all conditions and full formulary
The net benefit of the project is calculated by subtracting the costs of the project from the benefits in order to see the overall financial impact that implementing the project would have.

Year 1: £707,025 (benefit) - £100,500 (cost) = £606,525 (net benefit)

10 Year Period: £20,667,661 (benefit) - £782,753 (cost) = £19,884,908 (net benefit)

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

Net benefits with the assumption of 1% risk of an acute condition becoming a LTC:
Year 1: £288,465 (benefit) - £100,500 (cost) = £187,965 (net benefit)
10 Year Period: £7,236,457 (benefit) - £782,753 (cost) = £6,453,704 (net benefit)

Net benefits with the assumption of 5% risk of an acute condition becoming a LTC:
Year 1: £1,125,58 (benefit) - £100,500 (cost) = £1,025,085 (net benefit)
10 Year Period: £34,098,864 (benefit) - £782,753 (cost) = £33,316,111 (net benefit)

With the lowest estimate of the risk of an acute condition becoming a LTC the introduction of independent prescribing by physiotherapists is projected to result in a net benefit in both the short and long term.

Costs and benefits of Option 2: Independent prescribing for specified conditions from a specified formulary
Monetised costs incurred through Option 2 are taken to be the same as those outlined in Option 1, where the only cost is that of the independent prescribing educational programmes. The same course will need to be undertaken by podiatrists as that done under Option 1.This is because they will require the same level of prescribing knowledge as if they are prescribing independently with a full formulary for all conditions. They will still be prescribing independently but they will only be able to apply it to a specified list of medicines and to specified conditions. An additional cost, which is not monetised, is that of the cost of governance surrounding podiatrists only being allowed to prescribe for a specified formulary and to a specified list of conditions. The list of formulary and conditions would have to be outlined and it would need to be ensured that podiatrists only prescribe within this, in line with which enforcement measures and sanctions would need to be outlined.

The type of benefits under Option 2 will be qualitatively the same as those under Option 1, but the scale of benefits will be smaller than those under Option 1 because not all conditions or all possible prescriptions would be provided for. We might expect the limited prescribing to cover a sizeable proportion of conditions or formulary normally covered by podiatrists, but it would not be 100%. We take a working assumption that this proportion will be 70% given that under a specified formulary and limited to conditions there will be a restriction on service redesign, the podiatrists will lose the flexibility offered under Option 1 and lose the ability to evolve with ever changing medicines and newly recognised conditions. Ultimately this is expected to result in 30% less benefits passed on to the patient than under Option 1 in both monetised and non-monetised aspects.

On the assumption that the costs will be the same as Option 1 and benefits will be 70% of those in Option 1 the costs and benefits for year 1 and over the first 10 years are as follows.

Year 1: £787,910 (benefits) - £100,500 (costs) = £687,410 (net benefit)
10 Years: £23,869,205 (benefits) - £782,753 (costs) = £23,086,452 (net benefit)

Costs and benefits of Option 3: Independent prescribing for any condition from a specified formulary

Monetised costs incurred through Option 3 are taken to be the same as those outlined in Option 1, where the only cost is that of the independent prescribing educational programmes. The same course will need to be undertaken by podiatrists as that done under Option 1.This is because they will require the same level of prescribing knowledge as if they are prescribing independently with a full formulary, as they will still be prescribing independently but they will only be able to apply it to a specified list of medicines. An additional cost, which is not monetised, is that of the cost of governance surrounding podiatrists only being allowed to prescribe for a specified formulary. This formulary would have to be outlined and it would need to be ensured that podiatrists only prescribe within this named formulary. In line with this enforcement measures and sanctions would need to be outlined.

The type of benefits under Option 3 will be qualitatively the same as those under Option 1, but the scale of benefits will be smaller than those under Option 1 because not all conditions or all possible prescriptions would be provided for. We might expect the limited prescribing to cover a sizeable proportion of conditions or formulary normally covered by podiatrists, but it would not be 100%. We take a reasonable working assumption that in comparison, the benefits will be a proportion of those under Option 1. We take a working assumption that this proportion will be 80% given that under a specified formulary there will be a restriction on service redesign, the podiatrists will lose the flexibility offered under Option 1 and lose the ability to evolve with ever changing medicines. Ultimately this is expected to result in 20% less benefits passed on to the patient than under Option 1 in both monetise and non-monetised aspects

On the assumption that costs will be the same as Option 1 and benefits will be 80% of those in Option 1 the costs and benefits for year 1 and over the first 10 years are as follows.

Year 1: £900,468 (benefits) - £100,500 (costs) = £799,968 (net benefit)
10 Years: £27,279,091 (benefits) - £782,753 (costs) = £26,496,338 (net benefit)

Costs and benefits of Option 4: Independent prescribing for specified conditions from a full formulary

Monetised costs incurred through Option 4 are taken to be the same as those outlined in Option 1, where the only cost is that of the independent prescribing educational programmes. The same course will need to be undertaken by podiatrists as that done under Option 1.This is because they will require the same level of prescribing knowledge as if they are prescribing independently for all conditions, as they will still be prescribing independently but they will only be able to apply it to a specified list of conditions. An additional cost, which is not monetised, is that of the cost of governance surrounding podiatrists only being allowed to prescribe for specified conditions. These conditions would have to be outlined and it would need to be ensured that podiatrists only prescribe within these named conditions. In line with this enforcement measures and sanctions would need to be outlined.

The type of benefits under Option 4 will be qualitatively the same as those under Option 1, but the scale of benefits will be smaller than those under Option 1 because not all conditions or all possible prescriptions would be provided for. We might expect the limited prescribing to cover a sizeable proportion of conditions or formulary normally covered by podiatrists, but it would not be 100%. We take a reasonable working assumption that in comparison, the benefits will be a proportion of those under Option 1. We take a working assumption that this proportion will be 80% given that under a specified formulary there will be a restriction on service redesign, the podiatrists will lose the flexibility offered under Option 1 and lose the ability to evolve with ever changing medical conditions being recognised. Ultimately this is expected to result in 20% less benefits passed on to the patient than under Option 1 in both monetise and non-monetised aspects

On the assumption that costs will be the same as Option 1 and benefits will be 80% of those in Option 1 the costs and benefits for year 1 and over the first 10 years are as follows.

Year 1: £900,468 (benefits) - £100,500 (costs) = £799,968 (net benefit)
10 Years: £27,279,091 (benefits) - £782,753 (costs) = £26,496,338 (net benefit)

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 cost of any expansion of non-medical prescribing is training and they will be required to pay to train individuals and ensure that individuals maintain accreditation with the relevant professional body. The final section of the educational programme for independent prescribing requires a Designated Medical Practitioner (DMP) to supervise the podiatrist practising as an independent prescriber. The DMPs supervision does not impose a financial cost, as experience with current independent/supplementary prescribing programmes is that no cost is incurred in respect of their time.

Training programmes are commissioned locally and existing programmes are multidisciplinary[21] 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 annotated the supplementary prescriber qualification with the HPC will have the opportunity 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 time limited and only relevant to existing supplementary prescribers undertaking the conversion programme (a poll indicated that 95% 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 SHAs.

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 rational 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.

[21] 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 offer non-medical prescribing mechanisms by Patient Group Directions only.

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 very 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 have been 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. Avoidable delays in patient care and potential to reduce additional GP/medical appointments can affect the efficacy of care if podiatrists could safely prescribe the required medicine(s)
- 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 emphasises 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. Some patients with arthritic or musculoskeletal foot conditions could utilise personal budgets to self-refer to podiatry services and receive a one-stop service that manages their diagnostic, physical

and medicines needs. This would complement GP and/or hospital care, by allowing many patients greater convenience and greater self-determination.

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 UK[22] 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 evidence[23] 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 medication[24].

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)*[25] 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.

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

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

[23] 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

[24] Greenhalgh S. (2008), Bolton NHS Musculoskeletal Service. Unpublished audit data.

[25] 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/

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 literature[26]. 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 doctor[27] and difficulties when timeframes of care are short, such as short stays in hospital or one-off outpatient appointments[28].

Value for Money: In the 2009 *Allied health professions prescribing and medicines supply mechanisms scoping project report*[29] 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 prescribing[30]
- 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.
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

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

[27] 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

[28] 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

[29] 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

[30] Prescribed medicines cannot be supplied by the prescriber, they must be supplied by a separate dispenser

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 appointments. This would apply to community podiatry services and specialist podiatry-led musculoskeletal services. The podiatry self-referral pilots indicate that 24% of patients who self-referred to podiatry required a prescription for their condition, which suggests that there is potential for large reductions in GP appointments in this population. While patients would still have the option of visiting their GP, many would not need to if their 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 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 dangerous misuse) and 1% who needed the removal of medicines to improve care[31]. Additional positive patient and cost benefit effects is assumed as non medical prescribing is extended to other professions including podiatry.

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.

[31] Greenhalgh S. (2008), Bolton NHS Musculoskeletal Service. Unpublished audit data.

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 much more. There is a negative cost implication to maintaining the status quo because service efficiency and innovation are currently hampered by incongruence between the existing mechanisms and patient need.

Option 3 and Option 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, Option 1 in this consultation.

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 was the preferred option by respondents to the engagement exercise (72%), with independent prescribing by podiatrists from the full formulary for any condition.

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.

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)];

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.

The potential for a research project will be explored by the project board over the next six months including resources required.

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?]

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.

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]

The review will make use of mechanisms already in place for other prescribers at national, sub-national and local levels.

Baseline: [The current (baseline) position against which the change introduced by the legislation can be measured]

The baseline for all future data comparisons will be the data outlined throughout this impact assessment.

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]

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.

Monitoring information arrangements: [Provide further details of the planned/existing arrangements in place that will allow a systematic collection systematic collection of monitoring information for future policy review]

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.

Use will also be made of regional and local audits. Evaluations by the professional bodies will include private practitioners.

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

Totals 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. Total costs and benefits are calculated as the sum of 1 and 2 outlined below.

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

There were 96 supplementary prescribering podiatrists in April 2011. As a result of a sample survey of supplementary prescribers it is estimated that 96% will want to convert to independent prescribing. Therefore it is predicted that 92 podiatrists will want to convert from supplementary prescribing to independent prescribing. It is assumed they will convert over the first 2 years and then conversion programmes for podiatrists will no longer be avaliable. Hence, in the calculations below year 3 to 10 are shaded out as the calculations for conversion courses are over year 1 and 2 only.

Year	1	2	3	4	5	6	7	8	9	10	Projected financial saving over 10 year period	
Projected availability of conversion independent prescribing educational programmes												
Projected availability of places on independent prescribing education programmes per year	1,800	1,800										Correspondence with Bolton University, who have 50 places on two intakes per year.
Estimated percentage of places taken up by podiatrists	0.03	0.03										Independent prescribing courses are attended by several professions, including nursing. Given that nursing is 30 times the size of nursing it is assumed uptake by podiatrists will be
Additional places on independent prescribing programmes per year taken up by podiatrists =(projected availability of places on courses)x(percentage take up by podiatrists)	54	54										
Projected demand for conversion independent prescribing educational programmes												
Number of supplementary prescribing podiatrists wanting to convert to independent prescribing (assume that 60% of supplementary prescribers convert to independent prescribers in year 1 and 40% in year 2)	55	37										It is a moderate assumption that supplementary prescribing podiatrists will convert to indpendent prescribing in the proportions 60% and 40% in year 1 and 2 respectively
Projected resulting number of first appointments avaliable with an independently prescribing podiatrist in England (one appointment = one new patient)												
Estimated average number of first appointments per podiatrist in England	16	16										Based on there being 62,815 first appointments with NHS podiatrists in England in 2010 and 3,870 podiatrists working in NHS England. This gives an average 16 first appointments with physiotherapists in the NHS per year, which was assumed here to be true also in the private sector.
Projected additional number of first appointments avaliable with an independently prescribing podiatrist per year = (number of supplementary prescribers converting to independent prescribing)x(average number of first appointments per podiatrists)	880	592										
Projected cumulative number of appointments avaliable with an independently prescribing podiatrist per year	**880**	**1,472**										

Benefits of Option 1: Independent prescribing for all conditions from a full formulary for podiatrists as a result of supplementary prescribers converting to independent prescribers

1a) **Health benefit to patients from timely treatment, thereby reducing risk of acute condition becoming a long term condition (LTC)**

Currently if a patient requires a prescription at the suggestion of their podiatrist they must visit their GP to access the prescription. 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, which at worst can become a LTC. With independent prescribing the patient can access the prescription without visiting the GP and so their pathway becomes solely a visit to the podiatrist. This increases the immediacy of the treatment and reduces the window of opportunity for the patient's condition to deteriorate. Here, the patient's whose conditions do deteriorate are calculated to show the saving independent prescribing has to offer. It is done using an economic calculation called a Quality Adjusted Life Year (QALY), which is a calculation that takes into account the impact a health intervention has (in this case the introduction of independent prescribing) on an individual, allowing for the the quality and quantity of life change as a result.

Risk of acute condition becoming a LTC	0.03	0.03									This is an moderate estimate, given the lack of definitive evidence on this figure across conditions.	
Estimated additional number of patients this reduces the risk for per year	26	44										
Total number of patients independent prescribing reduces risk for per year	26	71										
Quality of life deterioration as a result of the acute condition becoming a LTC	0.2	0.2									Reference: Kind P., Hardman G. and Macran S. (1999), *UK Population Norms fro 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. A moderate assumption is taken here as 0.2	
Number of years of the LTC	1	1									We restrict our benefit calculation to 1 year as a conservative estimate, although in reality it might be more	
Resulting number of Quality Adjusted Life Years (QALYs) = (quality of life deterioration)x(number of years of deteriorated state of health)	0.2	0.2									A Quality Adjusted Life Year (QALY) is a calculation that takes into account the impact a health intervention has on an individual, allowing for both the quality and quantity of life difference.	
Value of one healthy QALY (£60,000 is the stated economic cost of one year of healthy life)	£60,000	£60,000									p63, DH Interim Technical Guidance on Impact Assessments, (2009), Department of Health	
Resulting financial benefit per patient = (number of QALYs)x(value of 1 QALY)	£12,000	£12,000										
Resulting estimated financial health benefit in England per year = (financial benefit per patient)x(number of patients that independent prescribing reduces risk for)	**£316,800**	**£846,720**										
Discounted at 1.5% per year	**£316,800**	**£834,207**										**£1,151,007**

1b) **Reductions in GP requirements**

Currently if a patient requires a prescription at the suggestion of their podiatrist they must visit their GP to access the prescription. The patient pathway is podiatrist --> GP, which can take between 24 hours and 2 weeks. With independent prescribing the patient can access the prescription without visiting the GP and so their pathway becomes solely a visit to the podiatrist. Here the saving as a result of not requiring the follow up GP appointment as a result of independent prescribing is calculated.

Number of first appointments with a NHS podiatrist in 2010 (and assumed to be the same each year thereafter)	62,815	62,815									
Proportion of GP appointments estimated to require a prescription	0.33	0.33									
Number of podiatry appointments estimated to require a prescription = (number of first appointments with a podiatrist)x(proportion of appointments requiring a prescription) (i.e. demand for appointments with a podiatrist that require a prescription)	20,729	20,729									
Number of appointments covered by independent prescribing podiatrists (i.e. supply of appointments with a podiatrist that can independently prescribe)	880	1,472									
Cost of a GP appointment to the GP practice	£36	£36									
Projected financial savings to GP practices in England = (number of appointments covered by independent prescribers)x(cost of a GP appointment)	**£31,680**	**£52,992**									
Discounted at 3.5% per year	**£31,680**	**£51,200**									**£82,880**

Cell D128, 'Treatment Speciality Table 2009-10', http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=895

Page 16, DH (2008), Self-referral pilots to musculoskeletal physiotherapy and the implications for improving access to other AHP services',

1c) **Reduction in patient's time away from work to access a prescription**

Currently if a patient requires a prescription at the suggestion of their podiatrist they must visit their GP to access the prescription. The patient pathway is podiatrist --> GP, which can take between 24 hours and 2 weeks. With independent prescribing the patient can access the prescription without visiting the GP and so their pathway becomes solely a visit to the podiatrist. Here the saving to the patient not having to attend the follow up GP appointment is calculated.

Moderate assumption of time required to attend a GP appointment (in hours)	0.75	0.75									
Average hourly wage in England	11.13	11.13									
Average earnings lost in order to attend GP appointment to access a prescription	£8.35	£8.35									
Projected saving to patients for not having to attend a GP appointment to access their prescription per year = (average earnings lost from attending a GP appointment)x(number of appointments covered by an independently prescribing podiatrist)	**£7,346**	**£4,942**									
Discounted at 3.5% per year	**£7,346**	**£4,775**									**£12,120**

1d) **Reduced prescriptions required due to more specialist treatment from podiatrist**

Independent prescribing will give podiatrists a greater ability to treat their patients. As patients self-refer to podiatrists and GPs refer patients to podiatrists patients will increasingly receive specialist treatment. There is evidence to say that this more specialist treatment will result in a reduction in prescriptions, likely prescribed by more general clinical practitioners. It is also as a result of an appointment with a podiatrist being approximately 30 minutes in length compared to an 11 minute GP appointment. More focus and specialised treatment for the patient will likely reduce the amount of prescriptions required.

Estimated percentage reduction of prescriptions required because of specialist podiatrist care	0.14	0.14										Page 17, 'Self-referral pilots to musculoskeletal physiotherapy and the implications for improving access to othe AHP services', Department of Health (2008), London
Projected reduction in GP appointments per year	123	206										
Cost of a prescription	£7.40	£7.40										Assumption: there is one prescription prescribed per appointment
Projected financial saving = (cost of a prescription)x(projected reduction in GP appointments per year)	**£912**	**£1,525**										
Discounted at 3.5% per year	**£912**	**£1,473**									**£2,385**	
Total projected financial saving per year	**£356,737**	**£891,655**									**£1,248,392**	

Costs of Option 1: Independent prescribing for all conditions from a full formulary for podiatrists as a result of supplementary prescribers converting to independent prescribers

Educational programme costs

Cost of conversion educational programmes	£600	£600										Sourced through correspondence with Andrea Holder, Professional Leadership Officer at the Department of Health
Number of conversion programmes undertaken per year	55	37										It is a moderate assumption that supplementary prescribing podiatrists will convert to indpendent prescribing in the proportions 60% and 40% in year 1 and 2 respectively
Cost of conversion programmes = (cost of one conversion programme)x(number of conversion programmes undertaken each year)	**£33,000**	**£22,200**										
Discounted at 3.5% per year	**£33,000**	**£21,449**									**£54,449**	
Total projected financial cost per year	**£33,000**	**£21,449**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£54,449**	

2 Full independent prescribing educational programmes

The costs and benefits from those with no prescribing background taking on independent prescribing are outlined below. Full independent prescribing educational programmes will be available over the 10 year period and so all 10 years projected figures are outlined.

Year	1	2	3	4	5	6	7	8	9	10	Saving over 10 year period	
Supply of independent prescribing educational programmes												
Estimated proportion increase in provision of independent prescribing educational programmes per year	0.0	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0		Assumption: supply of courses will expand as demand for courses increases
Projected availability of places on independent prescribing education programmes per year	1,800	1,980	2,178	2,396	2,396	2,396	2,396	2,396	2,396	2,396		Correspondence with Jeanette Sandiford from Bolton University, who have 50 places on two intakes per year.
Estimated percentage of places taken up by podiatrists	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03		Independent prescribing courses are attended by several professions, including nursing. Given that nursing is 30 times the size of nursing it is assumed uptake by podiatrists will be 3%.
Projected additional places on independent prescribing programmes per year	54	59	65	72	72	72	72	72	72	72		
Projected number of places on independent prescribing educational programmes available to podiatrists per year	**54**	**113**	**179**	**251**	**322**	**394**	**466**	**538**	**610**	**682**		
Demand for independent prescribing educational programmes												
Number of practising podiatrists in England with no prescribing qualifications	5,952	5,839	5,660	5,409	5,087	4,692	4,226	3,688	3,078	2,396		Year 1 figure is based on the number of fully practising members of the SCP. Year 2 onwards subtracts those who have since become independent prescribers from those as possible candidates to take on independent prescribing
Estimated percentage uptake of independent prescribing educational programmes by podiatrists	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05		
Projected demand of independent prescribing educational programmes by podiatrists per year	**298**	**292**	**283**	**270**	**254**	**235**	**211**	**184**	**154**	**120**		

Given that projected demand far outweighs projected supply of independent prescribing educational programmes it is assumed that all available programmes will be fully attended

Resulting number of first appointments avaliable with an independently prescribing podiatrist in England (one appointment = one new patient)												
Estimated average number of first appointments per podiatrist in England	16	16	16	16	16	16	16	16	16	16		Based on there being 62,815 first appointments with NHS podiatrists in England in 2010 and 3,870 podiatrists working in NHS England. This gives an average 16 first appointments with physiotherapists in the NHS per year, which was assume here to be true also in the private sector.
Projected number of first appointments avaliable with an independently prescribing podiatrist per year	864	950	1,045	1,150	1,150	1,150	1,150	1,150	1,150	1,150		
Projected cumulative number of appointments available with an independently prescribing podiatrist per year	**864**	**1,814**	**2,860**	**4,010**	**5,160**	**6,310**	**7,460**	**8,610**	**9,760**	**10,910**		

2a) Benefits of Option 1: Independent prescribing for all conditions from a full formulary for podiatrists as a result those with no prescribing background training as independent prescribers

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

Currently if a patient requires a prescription at the suggestion of their podiatrist they must visit their GP to access the prescription. 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, which at worst can become a LTC. With independent prescribing the patient can access the prescription without visiting the GP and so their pathway becomes solely a visit to the podiatrist. This increases the immediacy of the treatment and reduces the window of opportunity for the patient's condition to deteriorate. Here, the patient's whose conditions do deteriorate are calculated to show the saving independent prescribing has to offer. It is done using an economic calculation called a Quality Adjusted Life Year (QALY), which is a calculation that takes into account the impact a health intervention has (in this case the introduction of independent prescribing) on an individual, allowing for the the quality and quantity of life change as a result.

Risk of acute condition becoming a LTC	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03		This is an moderate estimate, given the lack of definitive evidence on this figure across conditions.
Estimated additional number of patients this reduces the risk for per year	26	29	31	34	34	34	34	34	34	34		
Total number of patients independent prescribing reduces risk for per year	26	54	86	120	155	189	224	258	293	327		
Quality of life deterioration as a result of the acute condition becoming a LTC	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2		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 and poor state of pain/discomfort in health as 0.123 and 0.286. A moderate assumption is taken here as 0.2
Number of years of the LTC	1	1	1	1	1	1	1	1	1	1		We restrict the LTC to 1 year as a conservative estimate, although in reality it might be more
Resulting number of Quality Adjusted Life Years (QALYs) = (quality of life deterioration)x(number of years of deteriorated state of health)	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2		A Quality Adjusted Life Year (QALY) is a calculation that takes into account the impact a health intervention has on an individual, allowing for both the quality and quantity of life difference.
Value of one healthy QALY (£60,000 is the stated economic cost of one year of healthy life)	£60,000	£60,000	£60,000	£60,000	£60,000	£60,000	£60,000	£60,000	£60,000	£60,000		p63, DH Interim Technical Guidance on Impact Assessments, (2009), Department of Health
Resulting financial benefit per patient = (number of QALYs)x(value of 1 QALY)	£12,000	£12,000	£12,000	£12,000	£12,000	£12,000	£12,000	£12,000	£12,000	£12,000		
Resulting estimated financial health benefit in England per year = (financial benefit per patient)x(number of patients that independent prescribing reduces risk for)	**£311,040**	**£653,184**	**£1,029,542**	**£1,443,537**	**£1,857,531**	**£2,271,525**	**£2,685,519**	**£3,099,514**	**£3,513,508**	**£3,927,502**		
Discounted at 1.5% per year	**£311,040**	**£643,531**	**£999,337**	**£1,380,479**	**£1,750,136**	**£2,108,567**	**£2,456,021**	**£2,792,745**	**£3,118,980**	**£3,434,963**	**£18,995,798**	

2b) **Reductions in GP requirements**

Currently if a patient requires a prescription at the suggestion of their podiatrist they must visit their GP to access the prescription. The patient pathway is podiatrist --> GP, which can take between 24 hours and 2 weeks. With independent prescribing the patient can access the prescription without visiting the GP and so their pathway becomes solely a visit to the podiatrist. Here the saving as a result of not requiring the follow up GP appointment as a result of independent prescribing is calculated.

Number of first appointments with a NHS podiatrist (2010)	62,815	62,815	62,815	62,815	62,815	62,815	62,815	62,815	62,815	62,815	
Proportion of GP appointments estimated to require a prescription	0.33	0.33	0.33	0.33	0.33	0.33	0.33	0.33	0.33	0.33	
Number of podiatry appointments estimated to require a prescription = (number of first appointments with a podiatrist)x(proportion of appointments requiring a prescription) (i.e. demand for appointments with a podiatrist that require a prescription)	20,729	20,729	20,729	20,729	20,729	20,729	20,729	20,729	20,729	20,729	
Number of appointments covered by independent prescribing podiatrists (i.e. supply of appointments with a podiatrist that can independently prescribe)	864	950	1,045	1,150	1,150	1,150	1,150	1,150	1,150	1,150	
Cost of a GP appointment to the GP practice	£36	£36	£36	£36	£36	£36	£36	£36	£36	£36	
Projected financial savings to GP practices in England = (number of appointments covered by independent prescribers)x(cost of a GP appointment)	**£31,104**	**£34,214**	**£37,636**	**£41,399**	**£41,399**	**£41,399**	**£41,399**	**£41,399**	**£41,399**	**£41,399**	
Discounted at 3.5% per year	**£31,104**	**£33,057**	**£35,133**	**£37,340**	**£36,077**	**£34,857**	**£33,678**	**£32,540**	**£31,439**	**£30,376**	**£335,602**

Cell D128, 'Treatment Speciality Table 2009-10', http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=895
Page 16, DH (2008), Self-referral pilots to musculoskeletal physiotherapy and the implications for improving access to other AHP services',

2c) **Reduction in patient's time away from work required to access a prescription**

Currently if a patient requires a prescription at the suggestion of their podiatrist they must visit their GP to access the prescription. The patient pathway is podiatrist --> GP, which can take between 24 hours and 2 weeks. With independent prescribing the patient can access the prescription without visiting the GP and so their pathway becomes solely a visit to the podiatrist. Here the saving to the patient not having to attend the follow up GP appointment is calculated.

Moderate assumption of time required to attend a GP appointment (in hours)	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	
Average hourly wage in England	11.13	11.13	11.13	11.13	11.13	11.13	11.13	11.13	11.13	11.13	
Average earnings lost in order to attend GP appointment to access a prescription	£8.35	£8.35	£8.35	£8.35	£8.35	£8.35	£8.35	£8.35	£8.35	£8.35	
Projected saving to patients for not having to attend a GP appointment to access their prescription per year = (average earnings lost from attending a GP appointment)x(number of appointments covered by an independently prescribing podiatrist)	**£7,212**	**£7,933**	**£8,727**	**£9,599**	**£9,599**	**£9,599**	**£9,599**	**£9,599**	**£9,599**	**£9,599**	
Discounted at 3.5% per year	**£7,212**	**£7,665**	**£8,147**	**£8,658**	**£8,365**	**£8,083**	**£7,809**	**£7,545**	**£7,290**	**£7,043**	**£77,818**

2d) **Reduced prescriptions required due to more specialist treatment from podiatrist**

Independent prescribing will give podiatrists a greater ability to treat their patients. As patients self-refer to podiatrists and GPs refer patients to podiatrists patients will increasingly receive specialist treatment. There is evidence to say that this more specialist treatment will result in a reduction in prescriptions, likely prescribed by more general clinical practitioners. It is also as a result of an appointment with a podiatrist being approximately 30 minutes in length compared to an 11 minute GP appointment. More focus and specialised treatment for the patient will likely reduce the amount of prescriptions required.

Estimated percentage reduction of prescriptions required because of specialist podiatrist care	0.14	0.14	0.14	0.14	0.14	0.14	0.14	0.14	0.14	0.14	
Projected reduction in GP appointments per year	121	133	146	161	161	161	161	161	161	161	
Cost of a prescription	£7.70	£7.70	£7.70	£7.70	£7.70	£7.70	£7.70	£7.70	£7.70	£7.70	
Projected financial saving = (cost of a prescription)x(projected reduction in GP appointments per year)	**£931**	**£1,025**	**£1,127**	**£1,240**	**£1,240**	**£1,240**	**£1,240**	**£1,240**	**£1,240**	**£1,240**	
Discounted at 3.5% per year	**£931**	**£990**	**£1,052**	**£1,118**	**£1,080**	**£1,044**	**£1,008**	**£974**	**£941**	**£910**	**£10,049**
Total projected financial saving per year	**£350,288**	**£685,243**	**£1,043,670**	**£1,427,595**	**£1,795,659**	**£2,152,550**	**£2,498,517**	**£2,833,804**	**£3,158,651**	**£3,473,292**	**£19,419,268**

Page 17, 'Self-referral pilots to musculoskeletal physiotherapy and the implications for improving access to othe AHP services', Department of Health (2008), London

Assumption: there is one prescription prescriberd per appointment

Costs of Option 1: Independent prescribing for all conditions from a full formulary for podiatrists as a result those with no prescribing background training as independent prescribers

Educational programme costs

Cost of full independent prescribing educational programmes	£1,250	£1,250	£1,250	£1,250	£1,250	£1,250	£1,250	£1,250	£1,250	£1,250	
Number of independent prescribing educational programmes undertaken each year	54	59	65	72	72	72	72	72	72	72	
Estimated cost of all independent prescribing courses undertaken	**£67,500**	**£74,250**	**£81,675**	**£89,843**	**£89,843**	**£89,843**	**£89,843**	**£89,843**	**£89,843**	**£89,843**	
Discounted at 3.5%	**£67,500**	**£71,739**	**£76,244**	**£81,033**	**£78,293**	**£75,645**	**£73,087**	**£70,615**	**£68,227**	**£65,920**	**£728,304**
Total projected financial cost per year	**£67,500**	**£71,739**	**£76,244**	**£81,033**	**£78,293**	**£75,645**	**£73,087**	**£70,615**	**£68,227**	**£65,920**	**£728,304**

Sourced via correspondence with Andrea Holder, Professional Leadership Officer at the Department of Health

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

Annual Cost	£100,500	£93,188	£76,244	£81,033	£78,293	£75,645	£73,087	£70,615	£68,227	£65,920	£782,753
Annual Benefit	£707,025	£1,576,898	£1,043,670	£1,427,595	£1,795,659	£2,152,550	£2,498,517	£2,833,804	£3,158,651	£3,473,292	£20,667,661

Average annual cost: £78,275
Average annual benefit: £2,066,766

Projected 10 year net benefit: **£19,884,907**

Annex 3: References

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