A long and winding road: Attaining independent prescribing rights for podiatrists

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On 24 July 2012, Lord Howe announced that legislation would be put before Parliament to enable podiatrists and physiotherapists to join their nurse, pharmacy and optometry colleagues as non-medical independent prescribers (Department of Health [DH], 2012), signalling another step in the bid to ensure a sustainable health service into the future.

As part of a wider agenda to address the challenges posed by demographic imperatives, DH policies – aiming to establish "new ways of working" that involve "breaking down traditional barriers" and "working across traditional professional boundaries" (DH, 2000a; 2000b; 2008; 2009) – appear eminently sensible. However, it would be naïve to suggest that all healthcare professions are likely to seamlessly adopt initiatives that so clearly threaten the privileges of role and task exclusivity; professions, by their very nature, act to protect and maintain exclusivity of knowledge and skills, which they attempt to translate into social and economic rewards (Macdonald, 1995). When threatened by boundary encroachment from neighbouring professions, jurisdictional disputes emerge, which are characterised by claims and counter claims aimed at justifying or undermining the case for change (Macdonald, 1995).

For the professions of podiatry and physiotherapy, the saga of access to medicines has been a battleground – the former case extending for over 30 years (Borthwick, 2008; Hawkes, 2009). Yet, in spite of reluctance in some quarters of the workforce to welcome this change, the vision first laid out in the DH's Crown Report of 1999 has now largely reached fruition; all the suggested candidates either have, or are about to be granted, independent prescribing status.

Further work is required. The next steps will involve new statutory instruments to amend existing legislation, which should hopefully be in place by late autumn 2012. Following this, the Health and Care Professions Council (HCPC) will undertake a public consultation on the new prescribing standards for podiatrists and physiotherapists to ensure effective regulatory control of their prescribing activity.

Once the prescribing standards are in place, the HCPC will need to respond to requests from those universities wishing to run the courses, as HCPC approval is a requirement. It is anticipated that a large number of educational institutions will seek to deliver these courses, which may mean some delay. However, a fair estimate is that the educational programmes will be available to

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podiatrists and physiotherapists by October 2013, with the first independent prescribers graduating in early 2014. Access to controlled drugs will now follow an almost separate path, with submissions to the Advisory Council on Misuse of Drugs required in the first instance, and Home Office approval needed in the longer term.

In part, this broadening of prescribing rights is due to the priority given to the policy agenda, which must ultimately override inter-professional rivalries and boundary disputes. It is also due, I would suggest, to the diligence, perseverance, skill and resilience of the DH team driving the process forward.

All too often, organisations such as the DH are viewed as bureaucratic monoliths, unable to keep pace with service or patient need, or simply obstructive to professional aspirations. Any such criticism in the case of pursuing the expansion of independent prescribing rights would be both unfounded and wholly unjustified. Having witnessed the project unfold at first hand, I am able to affirm the unwavering support, resolution and clear leadership demonstrated by the DH team throughout; their consistent focus on patient safety and care, alongside a meticulous attention to detail, as it navigated through a deeply complex process has been a revelation. It has had to prepare and conduct engagement and public consultation exercises, seek Home Affairs Committee approval, obtain Ministerial approval at each stage, construct and compose impact assessments, equality assessments, establish medicines management guidance documents, write outline curricular frameworks, adopt and embed prescribing competency frameworks, and undertake detailed submissions for robust hearings before the Commission on Human Medicines – each essential to securing the outcome signalled by Lord Howe's announcement.

Perhaps one area of practice in which the extension of independent prescribing status to podiatrists will have a large impact is that of diabetic foot care. The urgency of intervention for the management of active diabetic foot disease – primarily for the management of sepsis stemming from an infected foot ulcer – has been widely documented (e.g. NICE, 2011; Diabetes UK, 2012). With many podiatrists playing a key role in identifying and managing life- and limb-threatening diabetic foot ulceration, those who become independent prescribers in such clinical environments, we can hypothesis, will play a crucial role in ensuring that prescription antibiotic therapy is initiated in such a manner as to improve patient outcomes.

Our patients and professional colleagues owe the DH team a debt of gratitude for making possible an extension to podiatric and physiotherapeutic practice that will enhance access to medicines when and where they are most needed. Timely access to medicines has been a notable concern in the past, and this measure will undoubtedly help to address it. ■

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