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Independent prescribing in the UK

Workforce ambitions and implementation challenges

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Executive summary

This report explores the current and future direction of the independent prescribing workforce in the UK health care system. Independent prescribers are qualified non-medical health care professionals – including nurses, pharmacists and allied health professionals – who can prescribe medications autonomously. They must complete an independent prescribing qualification before becoming annotated on their professional register as an independent prescriber.

Independent prescribers are an important group of the workforce to focus on now.

- There are already nearly 100,000 independent prescribers in the UK, representing almost a quarter of the prescribing workforce as of the beginning of April 2025.

- Prescribing accounts for a significant proportion of NHS spend: in England in 2024/25, nearly £21 billion was spent on issuing medicines, appliances and medical devices, after central rebates.[1]

- Independent prescribers are envisaged to play an important role in shifting care from hospitals into community settings and supporting the growing proportion of the population living with long-term conditions – including working as part of multidisciplinary neighbourhood teams and in primary care.

- Rapid change in the independent prescribing workforce is anticipated: from this year, newly qualified pharmacists will be trained independent prescribers, and changes are expected in the range of medicines that allied health professionals can prescribe.

Independent prescribers can play a significant role in patient care – they hold responsibility for assessing patients, including diagnosis, and the

clinical management of care. Using the prescribing qualification in practice goes beyond just prescribing medications. It also includes reducing or stopping a patient's medication (known as 'de-prescribing'), medication reviews and 'medication reconciliation' (developing a comprehensive list of a patient's medications and dosages). All of these are essential for health care professionals when navigating more complex cases, particularly as the prevalence of multiple long-term health conditions (called 'multi-morbidity') increases in the population.

This report identifies current barriers, issues and opportunities in relation to independent prescribing, and emerging risks to the expansion of the workforce, particularly in community settings. The report draws on research literature, data from regulators and training providers, analysis of policy documents and interviews and focus groups with national and local stakeholders.

What do we know about the independent prescribing workforce?

Nurses form the largest professional group of qualified independent prescribers, accounting for 69% of independent prescribers (68,180 prescribers, 8% of all nurses). More than half of nurses in general practice are active independent prescribers. Data on nurses' prescribing rates in other settings is limited.

Pharmacists have the greatest proportion of their workforce qualified as independent prescribers and are the fastest-growing group (22,770 prescribers, 33% of all pharmacists). Pharmacists working in general practice are currently most likely to be active prescribers, while those in community pharmacy are least likely to be active prescribers.

Across allied health professionals, 4% of physiotherapists, 7% of paramedics, 7% of chiropodists/podiatrists and 5% of therapeutic radiographers held the independent prescribing annotation in November 2025.

Workforce planning for independent prescribers is lacking

Independent prescribing has developed over time to help improve the capacity of the NHS workforce, in response to both increased workload pressures faced across the health service and a growing need to manage care and medications for patients with multiple long-term conditions.

However, the workforce has developed in a piecemeal way across the professions, resulting in inconsistencies in the training and regulation of independent prescribers (discussed below). In parallel, there is a lack of overall oversight and planning of the independent prescribing workforce, to ensure that it can support policy ambitions for independent prescribing. For example, across the UK, there are initiatives to encourage people to get advice from pharmacists for common health conditions (for example, the Pharmacy First scheme in England), but there are significant challenges for independent prescribers to work in community pharmacy, including access to training and supervision. However, both Scotland and Wales have an ambition to have independent prescribers in every community pharmacy by 2030.

Meanwhile, there are differences in what nurses and allied health professionals can prescribe. Despite often training on the same courses, allied health professionals are comparatively more limited than nurses in their authority to prescribe controlled drugs. This limits the extent to which multidisciplinary community services teams can operate in a consistent way. Although nurses are the largest professional group of independent prescribers, and have greater access to training than allied health professionals, the policy direction for this group of prescribers is unclear, beyond the broader development of advanced clinical practice (which is to bring clarity and consistency to advanced clinical practice across the UK).

The most significant change in the independent prescribing workforce is that, from this year, pharmacists qualifying through the undergraduate Master of Pharmacy (MPharm) degree can act as independent prescribers at the point of registration, as alluded to earlier. The first cohort under these new standards are currently completing their foundation year and will join the register as independent prescribers from September 2026. We estimate this

will lead to several thousand more pharmacists joining the register each year, on the basis that over the last four years over 4,000 students have enrolled each year on the MPharm degree.[2] The introduction of these new MPharm graduates into the independent prescribing workforce creates a set of unique challenges. Namely, the cohort will be relatively inexperienced in their chosen area of practice for prescribing, and they will require robust supervision and continuing professional development to bring them to a level to be able to competently prescribe. Challenges with ensuring this cohort have access to structured supervision is a concern at a local level, with varying approaches taken to address these challenges.

Training and supervision

Although there are ambitions to expand the independent prescribing workforce, current training pathways, regulation and assurances may not be fit for purpose. The training pipeline is fragile. It is significantly underfunded in respect to the demand for health care professionals to complete the training and limited consideration has been given to aligning training with available supervisors (with knock-on consequences for local workforce planning). Local leads see increasing the amount of funding available for independent prescribing as a priority for change nationally, but this must be set against evidence that many prescribers cannot use their skills in practice.

'Designated prescribing practitioners' (qualified and experienced prescribers) supervise trainee independent prescribers throughout their training. But limited access to suitable designated prescribing practitioners is a significant barrier to accessing independent prescribing training. A lack of access to designated prescribing practitioners in the community is a challenge for pharmacists in particular, and we heard from local leads that workable solutions are often difficult to implement. This has significant implications for achieving the ambitions to expand independent prescribing in the community.

Prescribing in practice

Problems with a lack of supervision also affect recently qualified independent prescribers. Significant barriers exist to accessing supervision, all of which are particularly pronounced in the community setting. This issue will be exacerbated for the cohort of new pharmacists who will be qualifying as independent prescribers in September 2026. Limited supervision can have substantial impacts, including demotivating staff from working in the community and risking a more vulnerable workforce.

Continuing professional development (CPD) is essential to maintaining the knowledge and competency to safely prescribe. However, there are limited opportunities for independent prescribers to upskill and access CPD. Workload pressures and a lack of protected time to pursue CPD compound this. CPD opportunities are also not tailored to specific needs.

The extent to which independent prescribers are using their prescribing abilities in practice is difficult to determine. Where professionals are not actively prescribing, there is a significant risk that they will lose their prescribing skills and confidence, or seek prescribing roles outside NHS-funded services.

Governance and assurance

Professional regulators have all adopted the Royal Pharmaceutical Society's competency framework for prescribers.[3] Regulators are responsible for revalidation (the process that all health professionals must complete to maintain their registration with their regulator), but currently this does not include any additional requirements for independent prescribers. There are emerging risks around safety assurances, such as prescribers becoming deskilled when not prescribing within their current job role. Regulators are best placed to address these risks through the revalidation process.

Integrated care boards, health boards and NHS trusts have their own independent prescribing policies. Integrated care board policies are aimed at independent prescribers working in GP surgeries, community pharmacy

or other providers linked to the integrated care board's prescribing budget. An NHS trust's policies are aimed at independent prescribers working across the trust. As such, all independent prescribers are encompassed by the same policy, regardless of professional group or specialty. We heard that implementing and maintaining strong governance structures is more difficult for large trusts and integrated care boards that encompass a number of different specialist providers.

Looking outside NHS-funded services, independent prescribing is also growing in the private sector (as part of a growth in prescribing in the private sector overall). This comes with challenges, including rising competition to recruit and retain independent prescribers for NHS-funded services. It also represents a significant emerging risk, with concerns about the strength of governance in providers of private prescriptions, where prescribing activity is not visible. Again, this reinforces the argument that regulators need to play a more significant role in ensuring the safe practice of independent prescribers.

Data, monitoring and evaluation

Data for oversight of the independent prescribing workforce and their activity is limited. Regulators record who is annotated on the register, but not whether they are prescribing within their current role. This is a significant data gap. In primary care there is data on prescribing activity, but there is no data on the proportion of staff who are independent prescribers at an employer level in the health sector.

There is significant scope to improve the monitoring of prescribing practice, such as extending the current monitoring of antibiotic prescribing in primary care. Improving the monitoring of workforce activity and prescribing patterns would provide greater assurance that independent prescribing is working well, and it would support wider use of prescribing skills.

More broadly, while independent prescribing has become embedded in the NHS workforce, and is seen as core to the intended shift from hospital care to community and neighbourhood care, there is little evaluation of the quality, effectiveness or cost-effectiveness of independent prescribing roles.

Recommendations

Independent prescribing is not well addressed in national policies and plans on its own. Instead, it sits alongside a number of different workforce and other policies, including Pharmacy First, the Additional Roles Reimbursement Scheme, advanced clinical practice and wider policies such as the shift to community. Furthermore, there are gaps and inconsistencies between policies and across settings, which can create challenges when implementing in practice.

It will be essential that further iterations of the *NHS Long-Term Workforce Plan*, first published in 2023,[4] address the future of independent prescribing. This should include detailing what roles independent prescribers can be expected to undertake in neighbourhood health teams and taking steps to better integrate independent prescribing across multiple settings. The plan should consider providing evidenced modelling on the new MPharm graduates pipeline into the workforce, making sure to consider the requirement for stronger supervision.

Our recommendations are also targeted at regional workforce leads, ensuring that local workforce planning is underpinned by population need and considers how independent prescribing can help meet current and future demands. This includes ensuring that independent prescribers are working in services that can use their prescribing skills and incorporating supervision into regional planning.

A number of recommendations are centred around establishing consistent and robust assurances on the governance and regulation of independent prescribing. This includes addressing the limited consideration given to providing evidence of independent prescribing skills and competence within the revalidation process.

Our recommendations also aim to address the lack of data, monitoring and evaluation of independent prescribing in practice.

About this report

This report explores the current and future direction of the prescribing workforce in the UK health care system. It examines how prescribing rights have expanded beyond doctors and dentists to include a growing range of health care professionals, such as pharmacists, nurses and allied health professionals. This is in the context of broader goals to improve access to medicines (and reduce inequalities in access), patient outcomes and service efficiency. Prescribing accounts for a significant proportion of NHS spend. Prescribing accounts for a significant proportion of NHS spend. In England in 2024/25, nearly £21 billion was spent (after central rebates) on issuing medicines, appliances and medical devices, with growing spend in both primary care and hospital prescribing.*,[1]

Over time, UK prescribing practices have evolved in response to workforce pressures, rising demand for care and the goal of more integrated, patient-centred services. This rapid piece of work, which the Nuffield Trust (an independent health think tank) has carried out, funded by the Association of the British Pharmaceutical Industry (ABPI), examines the independent prescribing workforce within this context. We explore policy developments, access to training, the ambitions for growth in independent prescribing and the opportunities and challenges surrounding these ambitions.

The research took place between September 2025 and January 2026, and involved a mixed-methods approach, drawing on multiple sources. We undertook interviews with key stakeholders, including the Department of Health and Social Care, NHS England, professional associations, Royal Colleges and regulatory bodies. We complemented this with a rapid literature review, policy analysis of national strategies and plans, and analysis of data such as the numbers of registered independent prescribers. We also organised

* This spend includes branded and generic medicine and is inclusive of VAT on some secondary care medicines, and system costs such as pharmacy fees and wholesaler/supplier margins. Central rebates are the financial agreements between NHS England and pharmaceutical companies. Before central rebates the NHS spend in England was £21.6 billion.

focus groups with local leads from integrated care boards, health boards and NHS trusts to discuss local priorities for independent prescribing and where they see the key implementation challenges are. (See Appendix A for further details on our methodology.)

It is important to note that this work is not intended to evaluate the effectiveness or safety of independent prescribers, neither as a collective group nor for individual professions. We also do not focus on supplementary prescribers – staff who can prescribe in partnership with a doctor.

The report aims to inform stakeholders – policy-makers, regulators and health care professionals – about the important challenges to meeting the ambitions for the independent prescribing workforce, while drawing out opportunities for development and improvement.

Structure of the report

Chapter 1 explains what independent prescribing is, its purpose and what can be prescribed, as well as outlining the evidence on the safety, effectiveness and acceptability of independent prescribing.

Chapter 2 presents data on the number of qualified independent prescribers, and workforce trends, and discusses evidence about the settings and roles that independent prescribers are working in, and the extent to which they can use their prescribing qualification.

Chapter 3 sets out national policy ambitions for independent prescribing across the UK, the aims of different non-medical professions in relation to prescribing, and local ambitions.

Chapter 4 looks at access to independent prescribing training, including entry requirements, funding, the training pathway and pre-registration pharmacist training.

Chapter 5 focuses on the governance and regulation of independent prescribing, assurance and support.

Chapter 6 presents our main findings and highlights the cross-cutting themes from the research.

Finally, Chapter 7 sets out our recommendations for: the Department of Health and Social Care and, where relevant, the health departments of the devolved countries of the UK; regional workforce leads; and regulators, employers and professionals.

Glossary

Advanced clinical practice is a level of practice delivered by professionals who have completed post graduate qualification to increase their knowledge and skills, underpinned by the ability to make decisions on the assessment, diagnosis and treatment of patients.

Annotations are used to record additional postgraduate qualifications or specialisms on a professional register. The independent prescribing qualification is recorded as an annotation on a professional register.

Assurances refer to the governance, frameworks and safety measures that ensure independent prescribers are competent and safe to prescribe.

Controlled drugs are medicines subject to legal control under the Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2001. These drugs are subject to increased regulation as there is increased risk that they could be addictive and/or harmful.

De-prescribing is the process of reducing or stopping a patient's medication, in line with their health and care needs.

Designated prescribing practitioner is a qualified independent prescriber who supervises trainees completing their independent prescribing qualification.

Independent prescribing is prescribing carried out by a health professional other than a doctor or dentist.

Medication reconciliation is the process of developing a comprehensive list of a patient's medications and dosages. It includes recording a current list of

medications from the patient and reviewing health records before resolving any discrepancies and updating the patient and their records.

MPharm is the Master of Pharmacy, a four-year undergraduate degree to become a qualified pharmacist and, for the most recent cohort, an independent prescriber at the point of registration.

Off-label medication is where the medicine is used in a way that is different to what is outlined in the product licence. The licence states which illness the medication can be used for and how much to prescribe.

Prescribing scope of practice defines the prescribing activity that a health care professional can carry out within their role. They must have the knowledge, skills and experience to deliver this practice.

Non-medical prescribing encompasses both independent and supplementary prescribing. It is any prescribing carried out by a health professional other than doctors or dentists.

Supplementary prescribing is a subset of non-medical prescribing where there is a partnership between an independent prescriber and a supplementary prescriber to implement an agreed patient specific clinical management plan.

1 Introduction

What is independent prescribing?

Independent prescribing is prescribing carried out by a health care professional other than a doctor or dentist, where the prescriber takes responsibility for assessing patients with previously undiagnosed or diagnosed conditions and decides on the clinical management required. They may prescribe new medicines, change dosages or stop existing prescriptions, within the scope of their practice. And they may prescribe drugs detailed by profession-specific legislation and regulations. Independent prescribers have completed an approved prescribing qualification and are **annotated** on their regulatory body's register as prescribers.*

Health care professionals who can become independent prescribers include:

- nurses and midwives
- pharmacists
- physiotherapists
- podiatrists/chiropodists
- paramedics
- therapeutic radiographers
- optometrists.†

* The Nursing & Midwifery Council (NMC) regulates nurses and midwives, the General Pharmaceutical Council (GPhC) regulates pharmacists, the Health and Care Professions Council (HCPC) regulates professionals such as physiotherapists, podiatrists, chiropodists, paramedics and diagnostic radiographers, and the General Optical Council (GOC) regulates optometrists. In Northern Ireland, pharmacists are regulated by the Pharmaceutical Society of Northern Ireland (PSNI).

† Independent prescribing for optometrists is out of scope for this research. Data on the current number of optometrists who are independent prescribers is limited and the specialised nature of the role means the training and governance landscape differs significantly compared with that for other health care professionals.

Independent prescribing is a subset of **non-medical prescribing**, which also includes supplementary prescribing.[5]

Supplementary prescribing, which is out of scope for this report, is a partnership between a prescriber and a supplementary prescriber to implement an agreed patient-specific Clinical Management Plan with the patient's consent. In other words, a supplementary prescriber can only prescribe medicines within the limits of that plan. Professionals who can become supplementary prescribers (but not independent prescribers) include dietitians and diagnostic radiographers.

Additionally, but out of scope of this report, district nurses and public health nurses can complete a community practitioner nurse prescribing course. After qualifying, they can prescribe from a restricted formulary, including dressings and a limited number of prescription-only medicines.

What is the purpose of independent prescribing?

Independent prescribing in the UK was first introduced in the early 2000s and has developed over time (see Appendix B for more details on the history of independent prescribing). The rationale for introducing it was to improve timely access to medicines and improve patient safety by enabling trained clinicians to assess patients and make prescribing decisions within their scope of practice, without requiring a doctor. Enabling access to medicines through community pharmacists can also reduce inequalities in access to medicines.

Extending health care professionals' scope of practice to include independent prescribing has been described as key to supporting the effective delivery of NHS plans and developing the capacity and capability of the workforce.[6] With the NHS experiencing rising patient demand, workforce shortages and funding pressures, independent prescribing offers opportunities to better use health professionals' skills, streamline care and enhance service integration.[7] (See Appendix B for more details on the ambitions for independent prescribing across the UK.)

Non-medical [independent] prescribing can:

- enable quicker, more efficient access to medicines for people
- make best use of the range of skills of healthcare professionals
- help to address demand and workforce issues.

Source: Care Quality Commission guidance and regulation[8]

What medicines can independent prescribers prescribe?

Independent prescribers in the UK are accountable for the safe assessment, management and prescribing of medicines within their **prescribing scope of practice** – the area in which they have the necessary knowledge, skills, competence and training. Prescribing must also comply with the relevant legislative framework, regulatory standards, professional guidance and organisational policies. Prescribing beyond independent prescribers' scope of practice may constitute unsafe practice and a regulatory breach.

There are variations between professions in what independent prescribers are legally permitted to prescribe (see Table 1). For example, some professions may prescribe unlicensed medicines within their competence, while others cannot. There are also complex differences between professions in their authority to prescribe **controlled drugs** (drugs that are subject to high levels of regulation as they may be especially addictive or harmful). The scope of prescribing is expected to change over time, depending on the outcomes of the current UK government's consultation on extending physiotherapists' ability to prescribe controlled drugs, and introducing independent prescribing for diagnostic radiographers (for more information, see Table 4 in Chapter 3).

Table 1: Medicines that independent prescribers in the UK can prescribe

Profession	What they can prescribe	Can they prescribe controlled drugs?
Nurse independent prescribers (including midwives)	Any medicine for any medical condition within their competence	Yes, except those in Schedule 1 of the Misuse of Drugs Regulations 2001, and diamorphine, dipipanone and cocaine for the treatment of addiction
Pharmacist independent prescribers	Any medicine for any medical condition within their competence, including unlicensed medicine	Yes, except those in Schedule 1 of the Misuse of Drugs Regulations 2001, and diamorphine, dipipanone and cocaine for the treatment of addiction
Optometrist independent prescribers	Any licensed medicine for ocular conditions affecting the eye and the tissues surrounding the eye	No
Physiotherapist independent prescribers	Any licensed medicine for any medical condition within their competence, including 'off-label' medicine	Yes, but limited to: diazepam, dihydrocodeine, lorazepam, morphine, oxycodone and temazepam, by oral administration; morphine for injectable administration; and fentanyl for transdermal administration
Podiatrist independent prescribers	Any licensed medicine for any medical condition within their competence, including 'off-label' medicine	Yes, but limited to diazepam, dihydrocodeine, lorazepam and temazepam, for oral administration
Paramedic independent prescribers	Any licensed medicine for any medical condition within their competence, including 'off-label' medicine	Yes, but limited to: morphine sulfate and diazepam for oral administration or injection; midazolam for oromucosal administration or injection; lorazepam by injection; and codeine phosphate for oral administration
Therapeutic radiographer independent prescribers	Any licensed medicine for any medical condition within their competence, including 'off-label' medicine	Yes, but limited to: diazepam, tramadol, oxycodone, lorazepam and codeine phosphate, for oral administration; and morphine sulfate for oral administration or injection

The safety, effectiveness and acceptability of independent prescribing

While the main focus of this report is on the independent prescribing workforce, in this section we provide a summary of recent evidence on the safety, effectiveness and public acceptance of independent prescribing, to provide some context as we discuss the policy ambitions for expanding prescribing rights.

In the late 2000s, the Department of Health (now the Department of Health and Social Care) commissioned an independent evaluation of nurse and pharmacist prescribing in England, which it published in 2011. This found that nurse and pharmacist independent prescribers operate safely and prescribe appropriately and that there are high levels of patient satisfaction with their prescribing.[9] A large study that compared prescribing errors that independent pharmacist prescribers and doctors at a large acute NHS hospital trust made, found that pharmacists made significantly fewer prescribing errors than doctors and that they involved patients more in decisions about their medicines.[10] There is also evidence that independent prescribing by allied health professionals, such as physiotherapists and podiatrists, is effective, with high levels of acceptability and patient satisfaction.[6] Systematic reviews have shown that this is applicable across a range of settings, with no consistent evidence of adverse impacts on patient outcomes.[11]

However, across all health services, there is concern about antibiotic prescribing and the increasing prevalence of antimicrobial resistance. Community pharmacists' prescribing of antibiotics is monitored closely,[12] particularly in relation to the Pharmacy First scheme in England,[13,14] which enables pharmacists to manage seven clinical pathways without the patient needing to see a GP.

In addition, there is currently mixed evidence on the economics and cost-effectiveness of independent prescribing. A recent review found it difficult to draw conclusions on value for money because of the heterogeneity of evidence.[15] Some studies have shown that pharmacist prescribing is cost-effective across a range of health conditions, while others have found independent prescribing to be resource-intensive for nurses. Care delivered

by physiotherapist and podiatrist independent prescribers can be more costly than care given by non-prescribers due to longer consultations with the former,[6] although it may reduce the need for a separate consultation with a prescriber.

Overall, there is a need for high-quality evidence that rigorously evaluates the costs and consequences of independent prescribing, to help inform commissioning and policy decisions.

Public acceptance of prescribing by community pharmacists is generally high, with survey data from 2023 indicating that nine in 10 people in England (89%) say they would feel comfortable being referred to a pharmacy to be treated for a minor illness such as earache, and the same proportion say they would feel comfortable if a pharmacist gave them antibiotics without needing to see a GP for a prescription first.[16]

Participants in our interviews and focus groups also indicated that public acceptance of independent prescribing is generally strong, as it enables people to have faster access to care, and could also reduce inequalities. However, stakeholders indicated that for allied health professionals there is less public awareness of both the role of the different professions and prescribing specifically.

Lack of awareness of the prescribing services that pharmacists can provide can reduce the public's confidence in independent prescribing.[17] And local leads have raised the concern that inconsistency in the services provided across community pharmacy, including prescribing, creates confusion for the public.[18] In Scotland, there is a push to standardise community pharmacy services across the country before promoting these services to the public.

2 How many independent prescribers are there across the UK?

In this chapter we estimate the number of qualified independent prescribers across different professions in the UK, using published and requested data. We chart and analyse trends over time for nurses and pharmacists and provide a snapshot for allied health professionals. Throughout the chapter we compare trends across the four countries of the UK and between professional groups.

We also discuss the use of the independent prescribing qualification in practice, and outline our findings on the current and future demand for independent prescribing, across settings, specialities and the four UK countries.

We also reflect on the public's awareness and acceptance of independent prescribing.

Key findings

- As of the beginning of April 2025, there were more than 98,000 independent prescribers in the UK, accounting for almost a quarter of the qualified prescribing workforce (24%).

- Across the professions, pharmacists have the greatest proportion of their workforce qualified as independent prescribers (22,770 prescribers, 33% of all pharmacists), although nurses make up the greatest number, accounting for 69% of non-medical prescribers (68,180 prescribers, 8% of nurses).

- In November 2025, 4% of physiotherapists, 7% of paramedics, 7% of chiropodists/podiatrists and 5% of therapeutic radiographers held the independent prescriber annotation.

- The number of pharmacist independent prescribers is increasing at a faster rate than among the other professions and is expected to rise much further, especially given that all newly qualified pharmacists will become independent prescribers from September 2026.

- There is significant variation between the four UK countries in the proportion of health care professionals who can independently prescribe, and this differs according to professional group.

- Data on how many prescribers use their qualification is limited. Survey data for pharmacists suggests a higher proportion of staff prescribe in general practice than in other settings, with the lowest proportion of prescribers being in community pharmacy. More than half of nurses in primary care prescribe, but we do not know about nurses in hospital, mental health or community services.

- There was general agreement among stakeholders that allied health professionals use the independent prescribing qualification well when they first qualify. However, there are risks that when changing job roles, the opportunity to use the qualification may become more limited.

- Independent prescribers can be attracted to work for providers of private health services, where opportunities are expanding and prescribers can enhance their ability to practise and use their qualification. However, there is less visibility and oversight of the independent prescribing workforce in the private sector.

- Significant disparities in opportunities to use the prescribing qualification exist both between the four UK countries and across settings. The evidence suggests that professionals working in community settings in England or Northern Ireland face limited opportunities to prescribe, disincentivising this role and risking deskilling.

- Skills and training in de-prescribing are also important for ensuring that independent prescribers are using their skills most effectively.

We analysed data from professional regulators on whether registrants hold an independent prescribing annotation, to understand how widespread independent prescribing is across the four countries of the UK. Regulators – including the General Pharmaceutical Council (GPhC), the Nursing & Midwifery Council (NMC) and the Health and Care Professions Council (HCPC) – maintain statutory registers of qualified professionals, from which we derived the total number of qualified prescribers across different professions.

Later in this chapter (see page 27) we discuss the extent to which qualified independent prescribers are actively prescribing.

The scale of qualified independent prescribers

There were more than 98,000 qualified independent prescribers as of the beginning of April 2025, constituting 24% of the total qualified prescriber workforce (see Figure 1). Nurses form the largest proportion of independent prescribers, accounting for 69% (69,061 nurses and midwives), followed by pharmacists (23%, 22,770), with allied health professionals making up the remaining numbers.

Figure 1: Independent prescribers as a proportion of all prescribers, April 2025

Notes: AHPs = allied health professionals. Figure 1 does not include dentists as they are out of scope for this research. The General Dental Council's April 2025 register listed 44,187 registered dentists across the UK.
Sources: HCPC Register Data and Statistics as of 1 April 2025, GPhC Register Data Reports as of March 2025, NMC-requested data by profession as of 31 March 2025, data requested from the Pharmaceutical Society of Northern Ireland (PSNI) as of 31 March 2025 and GMC Register Data Summary as of 2025 (month not stated).

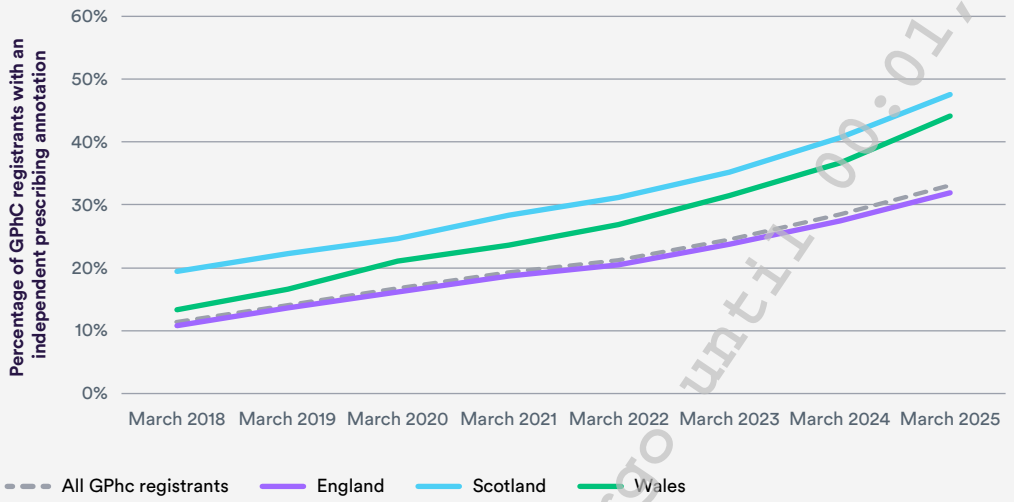
How has the number of qualified independent prescribers by profession changed over time?

Pharmacists

Trend data from the General Pharmaceutical Council (GPhC) shows that the number of pharmacists with an independent prescribing annotation has significantly increased over time, from 6,281 in March 2018 (11% of pharmacists) to 21,804 in March 2025 (33% of pharmacists). Scotland has consistently had the highest proportion of pharmacists with an independent prescribing annotation, followed by Wales and then England (see Figure 2). In March 2025, 48% of pharmacists registered in Scotland were independent prescribers, 44% in Wales were independent prescribers, 33% in Northern Ireland were independent prescribers* and 32% in England were independent prescribers. Reasons for these differences may relate to the ability to access funded independent prescribing training places and differences in the commissioning of prescribing in community pharmacy services in the devolved countries (see Chapter 3 for more information).

* We obtained this data from the Pharmaceutical Society of Northern Ireland (PSNI) for 31 March 2025. The total number of pharmacist independent prescribers in the UK is 22,770, this includes Northern Ireland.

Figure 2: Percentage of pharmacists on the General Pharmaceutical Council register with an independent prescribing annotation, by UK nation of registered address



Notes: The data for this chart is a snapshot of the register at 23:59:59 on the last day of the month specified. The geographical information for registrants is based on their most recent recorded address (on the regulator's system). The number of pharmacists with a prescribing annotation does not reflect how many are currently employed or working, but how many are on the GPhC register. Supplementary-only prescribers are not included. Comparable data for Northern Ireland is not available.
Source: Nuffield Trust analysis of data from the General Pharmaceutical Council

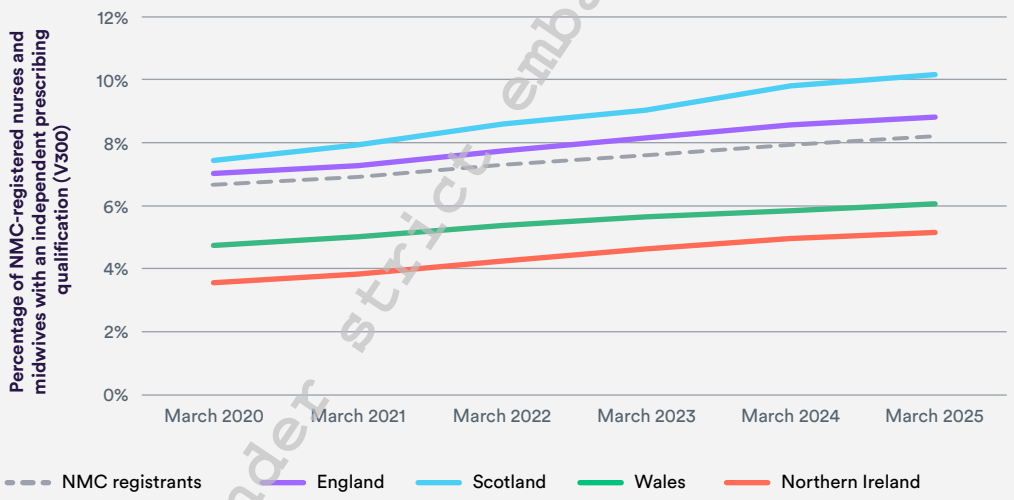
More recent monthly data shows that the total number of pharmacist independent prescribers has continued to increase; in November 2025, 25,008 pharmacists were registered with the annotation (37% of pharmacists). This trend is expected to increase further as, from September 2026 all newly qualified pharmacists will automatically enter the register as independent prescribers (see page 50). We estimate this will lead to several thousand more pharmacists joining the register each year. For example, for the last four cohorts over 4,000 students have enrolled each year on the MPharm degree.[2] The number of active prescribers will increase more slowly than the number who are qualified to prescribe, because there are not enough opportunities for newly *qualified* pharmacists to work in roles where they will use their prescribing skills.

Nurses and midwives

Data from the Nursing & Midwifery Council (NMC) shows that the number of nurses and midwives with an independent prescribing qualification* has also increased over time, from 47,595 in March 2020 (6.7% of registrants) to 69,061 in March 2025 (8.2% of registrants) (see Figure 3).† However, the increase over those five years was much more gradual than for pharmacists.

In March 2025, Scotland had the highest proportion of NMC registrants with an independent prescribing qualification (10%) followed by England (9%), Wales (6%) and Northern Ireland (5%). Almost all NMC registrants with a independent prescribing qualification were nurses (98.7% in March 2025) but some midwives also held the qualification (0.9%).‡

Figure 3: Percentage of nurses and midwives on the NMC register with an independent prescribing qualification, by UK nation of registered address



Notes: The data for this chart was measured on the last day of the month specified. The geographical information for registrants is based on their most recent recorded address (on the regulator's system). The denominator used for NMC registrants only includes nurses and midwives.
Source: Nuffield Trust analysis of data from the Nursing and Midwifery Council

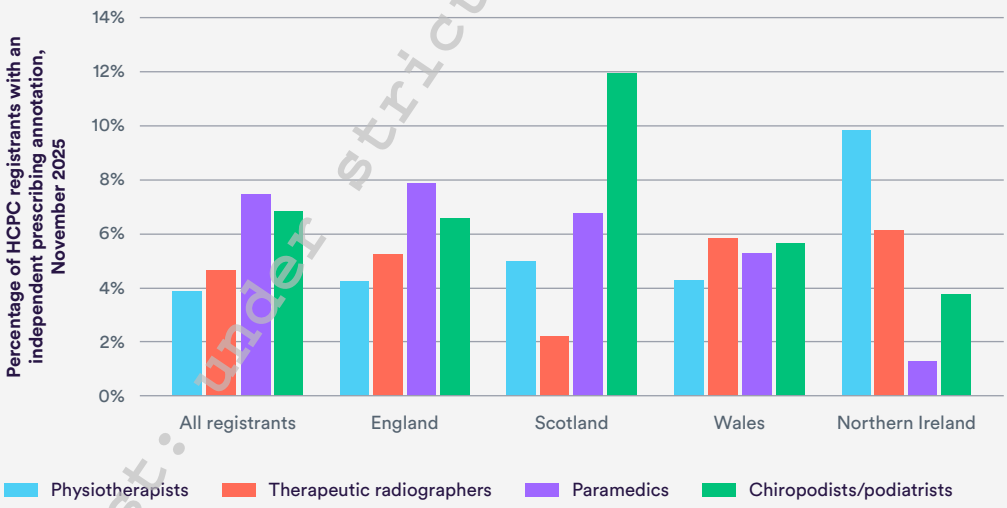
* The qualification is referred to within NMC data as V300 Independent/Supplementary Prescribing qualification.
† The number of NMC registrants used in the denominators does not include nursing associates, as they are not eligible to take the independent prescribing course.
‡ In March 2025, there were 602 midwives and 279 dual-registrant nurses and midwives with the V300 independent prescribing qualification.

Allied health care professionals

We also obtained data from the Health and Care Professions Council (HCPC), which shows the percentage of allied health professionals who hold an independent prescribing annotation, by professional group. As of November 2025, 3,161 physiotherapists were qualified to prescribe (4% of the 81,000 registered physiotherapists), 3,074 paramedics (7% of the 41,000 registered paramedics) were, 831 chiropodists/podiatrists (7% of the 12,000 registered chiropodists/podiatrists) were and 304 therapeutic radiographers (5% of the 43,000 registered therapeutic radiographers) were.

There is some variation between the four UK countries (see Figure 4). In Scotland, a higher proportion of chiropodists/podiatrists (12%) and a lower proportion of therapeutic radiographers (2%) are independent prescribers. Meanwhile, in Northern Ireland, a larger proportion of physiotherapists (10%) and a smaller proportion of paramedics (1%) are independent prescribers.

Figure 4: Percentage of allied health professionals registered with the Health and Care Professions Council with an independent prescribing annotation, by UK nation of registered address, November 2025



Notes: The geographical information for registrants is based on their most recent recorded address (on the regulator's system) as of November 2025.
Source: Nuffield Trust analysis of data from the Health and Care Professions Council

Are independent prescribers able to use their prescribing ability?

Using the prescribing qualification in practice goes beyond just prescribing medications. It should include de-prescribing, medication reviews and medication reconciliation. The role of independent prescribers and the extent to which they use their qualifications varies by profession.

Pharmacist prescribers work in general practice, hospital settings and community pharmacy. Pharmacists working in general practice (including primary care networks) are most likely to prescribe daily (77%), followed by hospital pharmacists (48%), with community pharmacists prescribing least often (30% prescribe daily), according to a 2025 survey of 581 pharmacists, of whom 253 were independent prescribers.[19]

We heard concern from local leads about the extent to which community pharmacists have the opportunity to use their prescribing qualification. In England, the NHS Community Pharmacy Independent Prescribing Pathfinder Programme was established in 2024 to inform the commissioning of community pharmacy clinical services.[20] This programme has now ended and the future national commissioning approach is not yet clear. Local leads perceived that there is a risk that pharmacist prescribers in the community will move to different sectors in order to be able to keep using their prescribing skills.

Similarly, we heard from stakeholders in Northern Ireland that there is a perceived risk that the new cohort of MPharm pharmacist prescribers entering the workforce in September 2026 will not want to work in a community setting as there is a lack of opportunity to maintain and use their prescribing skills in this setting.

Nurse prescribers are well established across the acute sector and in primary care. They include nurses working in nurse specialist roles who are supporting patients with long-term conditions or specific treatment needs, such as cancer, asthma, epilepsy or heart failure, in both acute and community settings.

While nurses are the largest group of independent prescribers in terms of volume, there is limited data about the extent to which they use their skills on a regular basis. For nurses working in hospitals, community services or mental health services, we were unable to find data to assess this. However, primary care data on prescribing by role, combined with primary care headcount data, indicates a high level of prescribing in the primary care nurse workforce: just over half of nurses working in primary care (53%) were independent prescribers in March 2025 (see Table B5 in Appendix B). It is unclear whether those who did not prescribe are qualified prescribers or not.

Local leads in our focus groups indicated that for nurses who are promoted to more senior management roles, it is likely that their ability to use their prescribing qualification could be limited.

We heard in our interviews with stakeholders from **allied health professions** that most independent prescribers can use their prescribing qualification in practice. This is particularly the case for podiatrists and therapeutic radiographers, as course entry is more limited to those individuals working in a service that requires the role. A recent national survey with physiotherapist independent prescribers identified that 18% were not actively using their prescribing qualification. Notably, the main reason for this was a change in job role, as for nurses.[21] This suggests that while an independent prescriber will likely be able to use their qualification in the role they qualified in, it does not necessarily mean they will have the opportunity to transfer these skills to a new role.

In our interviews across the allied health professions, stakeholders outlined which clinical settings and services independent prescribers work in (see Table 2). Some allied health professionals work primarily in advanced roles, whereas for nurses and pharmacists there is a greater range of opportunities.

Table 2: Where allied health professionals work and their roles

Professions	Clinical settings and roles
Paramedics	• Mainly work in advanced clinical practice roles • Have a role in primary care following the introduction of the Additional Roles Reimbursement Scheme (ARRS) • Out-of-hours, urgent and unscheduled care, including minor illness and walk-in centres
Physiotherapists	• Work primarily within a multidisciplinary team in a hospital • Musculoskeletal services, particularly in pain management • Neurological services • First-contact physiotherapist role in primary care
Podiatrists	• Work as part of a multidisciplinary team in a hospital • Majority work in advanced clinical practice roles • Diabetic high-risk and musculoskeletal services • High proportion also work outside the NHS in independent practice, including with sport injuries
Therapeutic radiographers	• Embedded in the therapeutic pathway within a hospital • Symptom management for patients going through radiotherapy

Source: Nuffield Trust stakeholder interviews for this research

Enhancing the ability of independent prescribers to de-prescribe medicines was also mentioned as a useful skill that could be better incorporated into training programmes. A focus-group participant raised concern that pharmacists were being monitored based on how much they prescribe and were set targets for prescribing more. The role of pharmacists in de-prescribing was highlighted as being important and requires monitoring.

Locally, which professions and settings are seeing increases in demand for independent prescribers?

We heard from stakeholders across our focus groups and interviews a clear demand for independent prescribing, particularly for expanding roles in the community.

Within our job adverts review (see Appendix A for more details), the majority of independent prescribing jobs advertised were within primary care. The review also identified a diverse range of roles in community and mental health services, which included homeless health, adult attention deficit hyperactivity disorder (ADHD) and alcohol and drug recovery services. This demonstrates how independent prescribers are well integrated across a number of different services.

These findings reflect what we heard in the focus groups. Local leads spoke of independent prescribers being used to plug gaps in local workforce. For example, a chronic shortage of consultant psychiatrists has fuelled an increase in independent prescribing in mental health settings. Local organisations have chosen to implement independent prescribing in these mental health roles as a cost-effective alternative to employing locum consultant psychiatrists. Other services with an increase in demand for independent prescribers include urgent care treatment centres and virtual ward services.

We heard how national policies, such as the Additional Roles Reimbursement Scheme (ARRS), have led to more paramedics and pharmacists working in general practice.[22] This is creating an opportunity to expand the independent prescribing role in general practice. As neighbourhood teams, as envisaged by the *NHS 10 Year Plan*,[23] become more established, the balance of prescribing roles at a local level may change.

We know from the literature that independent prescribers are already employed across a number of settings, including inclusion health and hard-to-reach groups.[24] Local leads were clear that local population needs should drive the decision to increase or develop independent prescribing

within a service. We heard how, in the future, neighbourhood hubs for specific conditions or populations (such as people with HIV or sickle cell disease) could encompass independent prescribing, as envisaged in the *NHS 10 Year Plan*.

Local leads also have ambitions to enable more health professionals to make better use of their ability to independently prescribe once qualified. For example, developing digital infrastructure could lead to more effective prescribing by enabling access to patient records across health care teams. Local leads identified ways in which regulation and oversight arrangements set at a national level could be improved to enable local ambitions to be realised. For example, enhanced monitoring and assurance of newly qualified prescribers, and improvements in supervision arrangements, would increase confidence among local employers and prescribers in their ability to prescribe safely and within their scope of practice.

Other professions' acceptance/awareness of independent prescribing

Across the different stakeholders we spoke to, including professional bodies and local leads, there was a consensus that medical and other professionals accept independent prescribing well. Support for independent prescribing is also reflected in a number of studies across settings and professional groups.[25] The multidisciplinary team approach has helped facilitate this integration of the role.[17]

The literature did identify some challenges for paramedics, however. Management had high expectations of paramedics, created by a lack of understanding of the boundaries of prescribing for paramedics compared to nurses.[26] We heard similar concerns around expectation within our focus groups. Local leads expressed that non-clinical service leads had less awareness of independent prescribing and that this led to unrealistically high expectations around how independent prescribing can support a service.

In the focus groups, local leads described a lack of awareness among some staff groups (including non-clinical staff) about what different professions can and cannot independently prescribe, resulting from the complex legal

landscape. A suggestion was made that since multiple professions undertake the same independent prescribing course but, on qualifying, are permitted to prescribe different medicines, there should be a more consistent approach. This echoes what we heard during our interviews with some of the Royal Colleges, and coincides with the agenda of the Independent Prescribing Rights Proposal Group (see Table 4 and, in Appendix B, Table B2). A more consistent approach would support service delivery and workforce planning in community services staffed by multidisciplinary teams, where different clinical professions undertake similar roles.

Independent prescribing in the private sector

Across our interviews and focus groups, stakeholders highlighted the increase in independent prescribing outside NHS-funded care. Private prescriptions account for a growing proportion of dispensed medicines: 4.7% in July 2025, an increase from 1.2% in July 2023.[27] Focus-group participants thought that services such as prescribing for ADHD, weight-loss drugs and aesthetics were driving this increase.

The growth in aesthetics prescribing was a growing safety concern among stakeholders we interviewed from nursing organisations. Aesthetic practice includes performing or assisting with a wide range of cosmetic procedures. In 2025, the Nursing & Midwifery Council (NMC) strengthened its position on the prescribing of non-surgical cosmetics.[28] It now requires nurse and midwife prescribers to carry out face-to-face consultations before they prescribe any products for elective non-surgical cosmetic procedures.

The increase in the employment of independent prescribers in the private sector was understood to be relevant to all professions, although it was seen as particularly attractive to pharmacists due to increased flexibility in what can be prescribed, combined with the opportunities it provided to implement prescribing skills more quickly after qualification.

Local leads have found the expansion of the private sector workforce challenging to manage, creating rising competition to both retain and

recruit independent prescribers for the NHS. We also heard examples of people being trained through funded places who later left to work in the private sector. Independent prescribers may also work both in the NHS and privately, particularly physiotherapists and podiatrists and increasingly nurses in aesthetics.

It is more difficult for professionals who work in the private sector to meet the entry requirements for independent prescribing courses. Some universities will not accept self-funded applicants. There are also more governance barriers in place and challenges around securing a designated prescribing practitioner, with a reported supervision bottleneck in the private sector.

Additionally, we heard concerns throughout our interviews and focus groups about the strength of governance structures and assurance in place in the private sector. One is that private sector organisations may lack the support and supervision structures that are in place for employees of an NHS organisation (for example, a trust or primary care network), such as appraisals, supervision and peer support. The second concern is that there is no oversight of their work: prescriptions that are not reimbursed under the NHS payment system are not recorded in the NHS Business Services Authority's database – the main route for integrated care board pharmacy leads to monitor prescribing activity. Overall, there is felt to be a gap in data and evidence about the safety and effectiveness of independent prescribing in the private sector.

3 Ambitions for independent prescribing

In this chapter we explore the national ambitions for independent prescribing in each of the four UK countries, outlining similarities and differences. After this we discuss independent prescribing in the context of NHS strategy and workforce plans, and provide a breakdown of profession-specific ambitions for independent prescribing. We then delve into some more local priorities.

Key findings

- All four UK countries have ambitions that relate to newly qualified pharmacists becoming independent prescribers from September 2026, with most aiming to enhance the role of pharmacists in community pharmacies.

- There are differences across the UK in the national commissioning of community pharmacy independent prescribing: Wales has the Pharmacy Independent Prescribing Service (PIPS), Scotland runs Pharmacy First Plus, England's Pathfinder Programme has ended, with the potential for independent prescribing to be included as a local or national element of the contract, and Northern Ireland plans to introduce independent prescribing to community pharmacy services (although this is subject to funding).

- Key ambitions and policy for nurse independent prescribing date back to the 1990s. Now, nurse independent prescribing is well established in the workforce and ambitions tend to align with those for advanced nursing practice.

- Allied health professionals – including speech and language therapists, dietitians, occupational therapists, diagnostic radiographers and operating department practitioners – are campaigning for independent prescribing rights.

- Local independent prescribing leads (in NHS hospitals, integrated care boards and health boards) have general ambitions to expand and better integrate the independent prescribing workforce to improve patient care. However, there are implementation challenges that range from access to independent prescriber training to securing designated prescribing practitioners who can supervise.

What are the national ambitions for independent prescribers in pharmacy?

All four UK countries have strong ambitions for their independent prescribing workforce in community pharmacy. Table 3 outlines some of the key policies across the four countries relating to this, including workforce ambitions and funding as well as national plans for community pharmacy (see Appendix B for more details).

Table 3: Key policies for independent prescribing in community pharmacy across the UK

Country	Pharmacy workforce	Community pharmacy
UK-wide	• Newly qualified pharmacists are to become independent prescribers at the point of registration from September 2026.	
England	• NHS England has funded 3,300 independent prescribing training places for pharmacists.	• The *NHS 10 Year Health Plan* outlined a transition to community pharmacy providing more clinical services.[23] • The NHS Pharmacy First service enables patients to be referred to a community pharmacy for a minor illness or urgent repeat medicine supply.[13] • The Pathfinders Programme ended in December 2025 and a new national service offer is currently being consulted on.[30]
Scotland	• There is an ambition that all patient-facing pharmacists will be an independent prescriber by 2030.[31]	• The NHS Pharmacy First Plus service allows pharmacist independent prescribers to prescribe for a wide range of clinical conditions.[32] • There is an ambition that all community pharmacists will provide Pharmacy First Plus services by the early 2030s.[32]
Wales	• National guidance for independent prescribers and competency assurance standards were published in 2024.[33]	• The Pharmacy Independent Prescribing Service enables patients to see an independent prescriber in a community pharmacy.[34] • There is an ambition for there to be an independent prescriber in every community pharmacy by 2030.[35]
Northern Ireland	• The Northern Ireland Centre for Pharmacy Learning and Development is funding 150 independent prescribing training places for pharmacists.[36]	• There is currently no nationally commissioned service. • The *Community Pharmacy Strategic Plan 2030* has ambitions for community pharmacist independent prescribers to be embedded in services.[37]

Source: Nuffield Trust review of published policy documents (see Appendix B for more details)

What are the profession-specific ambitions?

For nurses, independent prescribing has a long history, with key policy papers and ambitions dating back decades, starting with the publication of the Crown Reports in 1989 and 1999, which endorsed nurse independent prescribing (see Appendix B). Nurse independent prescribing is now well-established practice and an important element of advanced clinical practice, within the advanced-level nursing framework that the Royal College of Nursing has developed.[38] However, the Royal College of Nursing also outlines that independent prescribing is not exclusive to advanced clinical practice and that enhanced-level practice can also include prescribing.*[,38]

Individual allied health professions have their own agendas to expand their prescribing rights (see Table 4; see Table B2 in Appendix B for more details). For allied health professionals who can already access independent prescribing, ambitions are primarily aimed at expanding the number of controlled drugs they can prescribe. There are also a number of other allied health professionals with specific ambitions to be able to access independent prescribing.

* Advanced clinical practice is a level of practice delivered by a health care professional with substantial expertise to lead and deliver higher-level care. Enhanced nurse practice is more specialised and involves applying knowledge and skills to a specific area of practice.

Table 4: Allied health professions' strategies for independent prescribing

	Strategy
The **British Dietetic Association (BDA)** is campaigning for dietitians to gain independent prescribing rights	The objectives of the campaign include collecting data to provide evidence of dietitians' safe and effective prescribing and to influence government policy to support the transition to independent prescribing.[39]
The **#PrescribingNow** campaign across a number of allied health professional bodies	This campaign calls for the expansion of independent prescribing rights to specified allied health professionals across the four UK nations.[40]
The **Independent Prescribing Rights Proposal Group**	This is a group of health care professionals from across the UK, directing a proposal to allow allied health professional independent prescribers the ability to prescribe all licensed and unlicensed medications, including controlled drugs, for any medical condition within their scope of practice and competency.[41]
The consultation to **extend medicines responsibilities for allied health professions**	The Department of Health and Social Care ran a consultation from August to October 2025, seeking views on extending medicines responsibilities for four allied health professions.[42] The proposed changes relating to independent prescribing include: • **physiotherapists** – allowing them to prescribe four additional controlled drugs beyond the seven already permitted • **diagnostic radiographers** – permitting advanced, enhanced and consultant diagnostic radiographers to train as independent prescribers.

Source: Nuffield Trust analysis of various strategy documents

The findings in Table 4 on profession-specific ambitions corroborate what we heard during our interviews with various Royal Colleges. Individual professions have aims to expand their prescribing rights to improve patient care, provided that health professionals continue to prescribe safely and within their scope of practice. For example, the Royal College of Podiatrists is seeking to add to the present list of four controlled drugs that podiatrists

can independently prescribe across the UK.[43] A formal consultation was undertaken in 2020,[44] but this has not yet resulted in changes to regulations, and so progress has been slow. The Chartered Society of Physiotherapy, the College of Paramedics and the Society of Radiographers are all awaiting the results of the recent consultation to extend medicines responsibilities for four allied health professions (see Table 4).

During our interviews, we heard that piecemeal change to prescribing legislation has contributed to frustration, particularly around expanding access to controlled drugs for different allied health professionals. The length of time needed to change legislation, particularly in the context of Brexit and the Covid-19 pandemic, has led to delays in prescribing rights being legally changed. For example, the changes to legislation post-Brexit, such as the introduction of Medicines and Medical Devices Act 2021, has meant that previous consultations to change medicines responsibilities are currently being re-consulted on.

In order to expand the number of controlled drugs that independent prescribers can prescribe, legislative changes to both the Human Medicines Regulations 2012 under the Department of Health and Social Care and the Misuse of Drugs Act 1971 under the Home Office are required. Changes to controlled drug prescribing has been delayed in the past as the legislative changes to the Misuse of Drugs Act that are needed are relatively low on the Home Office's agenda compared to its other key policy areas. Recent research on independent prescribing for podiatry has highlighted these concerns and suggests that a joint set of processes and procedures between the Department of Health and Social Care and the Home Office could streamline everything and prevent future delays.[45]

During our interviews, we heard mixed views from professions about potential ambitions to change the level of experience required before being eligible to train as independent prescribers (when a health professional can train to prescribe). For example, the College of Paramedics indicated that it wished to retain the current standards for paramedics to be working at an advanced practitioner or equivalent level and normally have at least three years post-qualification experience in the clinical area in which they will be prescribing, before training as independent prescribers.[46] Conversely, the Royal College of Nursing stated that independent prescribing is not exclusive

to an advanced practice level and nurses who are not working at this level can also undertake training. The Chartered Society of Physiotherapy indicated a future ambition to move prescribing closer to the point of undergraduate qualification, provided it is done safely and for the benefit of patients.

In our interviews, some Royal Colleges expressed dissatisfaction that while several allied health professions train on the same or parallel courses as nurses to become independent prescribers, they qualify with different prescribing rights. This went hand-in-hand with competition for course places, where some professions felt they were competing with others for training budgets. Stakeholders conveyed a view that in terms of prescribing rights (what independent prescribers can prescribe) the allied health professions should be treated as a single profession, acknowledging that there are multiple professions aiming to expand their rights and that they are all covered by the same competency framework.[3]

What are the local priorities for independent prescribing?

In December 2025, we held focus groups with leads from NHS trusts, integrated care boards and regional NHS health boards to discuss their local priorities for independent prescribing (see Appendix A for more details). The majority of local leads expressed the high importance of and upcoming focus on both expanding the number of independent prescribers across a range of settings and how to make the best use of their prescribing expertise to the benefit of patients. Local priorities echoed the national ambitions discussed in relation to community pharmacists in the first section of this chapter.

However, they also extended beyond this, with local leaders identifying opportunities for independent prescribing to address wider workforce gaps, and support the shift of care from hospitals to community settings. Independent prescribers could also improve productivity by reducing duplication in staff roles – with examples given of cases where a nurse or pharmacist assessing a patient's medication in hospital can enact the change required without getting this separately signed off by a resident doctor. Further, local leads spoke of developing services based on areas

of higher community needs such as obesity or hypertension, using the non-medical workforce.

The upcoming change for newly qualified pharmacists in September 2026 was discussed during the focus groups. Local leads indicated the challenges of transforming community pharmacy in the context of wider NHS reforms such as the merging of integrated care boards and the abolishment of NHS England. The word 'vulnerable' was used to discuss newly qualified pharmacists in the context of there being limited assurances that they had the competency to prescribe in their area of practice (see Chapter 5). The challenge of accessing designated prescribing practitioners to supervise trainee independent prescribers (see Chapter 4 for more information) was also raised, and a priority was finding solutions to this problem. Some local leads expressed the desire for the national commissioning of independent prescribing in community pharmacies, with concern that in some regions the lack of funding was resulting in prescribing pharmacists not using their prescribing skills, with some turning to private prescribing (see Chapter 2), such as offering travel vaccinations.

Local priorities also centred on increasing independent prescribing across a broader range of health professions and settings. Staff shortages are a significant concern to local leads and increasing the use of independent prescribing across primary care and community settings was noted as one solution.

4 Access to independent prescribing training

In this chapter we cover the training of independent prescribers. We describe the entry requirements outlined by the regulators and employers. We also highlight the challenges with accessing independent prescribing courses, including access to funding and a designated prescribing practitioner. We also outline the changes to the Master of Pharmacy (MPharm) undergraduate degree.

Key findings

- Independent prescribing training is heavily linked to the employer. The employer holds responsibility for deciding who accesses funded places and providing evidence that candidates meet the course entry requirements on certain skills, including diagnosis and clinical assessment.

- We repeatedly heard the challenges around accessing funding for training places. These challenges created difficulties with managing the local workforce and led to high competition between professions in terms of accessing funded places.

- Stakeholders repeatedly raised the challenges with finding a designated prescribing practitioner (DPP), to supervise independent prescribers in training. There was a strong consensus that access to a DPP varies significantly across settings, with those in community settings facing larger barriers.

- Key questions remain about the new cohort of Master of Pharmacy (MPharm) graduates who will be able to prescribe at the point of qualification. This includes how to ensure access to education, training and supervision in an identified area of prescribing practice.

How do health care staff become independent prescribers?

To become an independent prescriber, health care professionals must undertake an independent prescribing course provided by an approved education institution. Courses are approved against a set of standards outlined by the regulators. All regulators stipulate that courses must deliver outcomes that meet the competencies outlined in the Royal Pharmaceutical Society's competency framework (see page 55),[3] including on managing prescribing and carrying out a patient consultation.

Practice learning is a significant part of an independent prescribing course; it is essential for building confidence.[47] Trainees must be able to apply the academic theory they learn about to practice. A designated prescribing practitioner (DPP) supervises practice learning and they are responsible for ensuring a trainee has met the required competencies). An applicant to an independent prescribing course must have a confirmed DPP in place, to oversee, support and assess their competence in the practice learning setting.[48]

In our interviews, stakeholders generally perceived the independent prescribing course to be robust and challenging. Courses usually take six months to complete and are undertaken on a part-time basis. Health professionals from different professions undertake courses together, which our stakeholders perceived to be beneficial for learning.[49] Some approved education institutions provide the same course for all professionals, although for the majority of courses we looked at, only nurses, midwives and allied health professionals train together, with pharmacists usually on a separate course.

The education standards from regulators stress the importance of having a balance between theory and practice. This includes 26 days of structured learning and a requirement of at least 78 hours of clinical practice (90 hours for pharmacists). Approved education institutions' courses are generic, applicable to all settings and services. Health professionals then tailor their practice learning hours and self-directed learning to their area of speciality.

How do entry requirements for independent prescribing courses vary across professions?

The regulators set minimum entry requirements and these vary for each professional group. Entry requirements rely heavily on the ability to demonstrate certain skills, particularly around diagnosis and clinical assessment. This is usually evidenced through employer support, which is required to undertake the course. In turn, employers are responsible for providing evidence on whether applicants meet the required competencies.

There is no minimum number of years of experience following registration required before pharmacists can enter an independent prescribing course. This follows changes in 2022 to pharmacy education, which saw the removal of the two-year post-registration requirement. Instead, General Pharmaceutical Council (GPhC) standards now require applicants to have relevant experience in a pharmacy setting.

For nurses, following the new Nursing & Midwifery Council (NMC) education standards in 2019, the entry requirement has been reduced from three to one year post-registration experience. However, there is no evidence that this will lead to an increase in the number of independent prescribers. In fact, we heard from stakeholders that it is unlikely that many nurses will be entering a training course one year post registration because the diagnostic skills requirement is unlikely to be met in this timeframe.

There is some evidence to suggest a need for clarity on how the competence of an applicant is assessed. Studies have identified some students entering prescribing programmes have gaps in knowledge on assessment and diagnosis skills and pharmacological knowledge.[50] And we heard in our interviews that this is particularly important since the changes to nursing standards in 2019. There is now a greater need for clarity on what measures will be taken to assess the competence and ability of nurses who wish to undertake a prescribing course.

There are apparent differences in entry requirements to independent prescribing courses across the different allied health professions. While HCPC standards stipulate that allied health professionals need to be on the register for three years before they can start the course (see Table 5), the courses we reviewed were consistent on further requirements for paramedics, particularly on the number of years they need to be on the register before course entry. For example, the courses we reviewed required five years of post-registration experience and also specifically that paramedics must be working at or towards an advanced level of practice. This is in line with findings from our stakeholder interviews, which emphasised that the course requires paramedics to have an advanced skillset, including proficiency in diagnostics and assessment. Conversely, we heard in the interviews that physiotherapists are autonomous practitioners who have the required diagnostic skills at the point of registration.

Table 5: Requirements for course entry

Professional group	Post-registration experience	Additional experience	Further requirements
Nurses and midwives	One year		• The applicant has clinical competence in diagnosis, clinical assessment, planning and the evaluation of care • Necessary governance is in place at the organisation • The applicant has been working in a role with an identified need for prescribing (usually for at least a year) • Support from a designated prescribing practitioner is in place
Pharmacists	No requirement	Relevant experience in a pharmacy setting	
Paramedics	Three years	Usually working towards an advanced level of practice	
Physiotherapists	Three years		
Podiatrists	Three years		
Therapeutic radiographers			

Source: GPhC (2022) Standards for the Education and Training of Pharmacist Independent Prescribers,[51] HCPC (2019) Standards for Education Providers and Registrants[52] and NMC (2024) Standards for Prescribing Programmes[53]

What are the requirements for accessing a designated prescribing practitioner?

Historically, medically qualified doctors or dentists carried out the role of supervisor for an independent prescriber in training – as a designated medical practitioner. But regulatory changes in 2019 enabled this role to be expanded and carried out by multi-professional independent prescribers, to address growing demand for designated prescribing practitioners (DPPs). Although formal training for the role is not required, the DPP must meet all of the competencies in the Royal Pharmaceutical Society's DPP competency framework,[54] be an experienced prescriber, usually with three years' experience, and meet other requirements such as having experience in training or teaching.

Stakeholders viewed these changes positively. In particular, local leads highlighted that the expansion of the role removed the reliance on general practitioners, improving access to training. However, demonstrating that they have the requirements to be a DPP can be a barrier for pharmacists, and the additional work may be off-putting.[55]

With more newly qualified independent prescribers entering the workforce, the pool of professionals eligible to be DPPs will expand in the future. However, in the short term, there will be an increase in demand for DPPs, and there is a risk that professionals with less experience may step into the role. It is important that DPPs are experienced prescribers with the skills and competencies to support prescribers in training.

Access to a designated prescribing practitioner

The literature and our focus groups point to geographical differences in access to a DPP.

The literature highlights regional disparities in England, with not enough DPPs in London and the South East to support the number of trainee pharmacist independent prescribers. The same research has demonstrated the success of running specific courses to increase the number of DPPs in general practice.[56]

We heard in our focus groups that challenges in identifying a DPP are particularly acute in Northern Ireland. With a small cohort of independent prescribers, community pharmacists rely heavily on medical professionals to take on the role of DPP. To incentivise the DPP role, a £1,500 grant is available for professionals wanting to support a community pharmacist in Northern Ireland.[36] Despite this, we heard that challenges still remain and self-sourcing a DPP comes with additional concerns around equality of access.

Access to a DPP also varies significantly by setting. Stakeholders told us that finding a DPP in a hospital setting and in general practice is easier as there are more staff in the organisation who are eligible to be DPPs than in unscheduled care and community settings. There is a clear tension between ambitions to expand the number of independent prescribers in the community and having a sufficient number of DPPs to support access to training for this group.

A lack of DPPs in community pharmacy means that pharmacists often have to look outside the community setting for a DPP. Locally, there has been a particular focus on securing more DPPs to support pharmacists in the community into training. We heard examples of local networks and dashboards to help pharmacists find a DPP. In Kent, the Coach a Pharmacist Prescriber portal is currently being trialled to help match pharmacists across the system to access a DPP.[57]

However, local leads emphasised that working with a DPP from a different employer can be challenging. This is primarily because access to independent prescribing training is heavily reliant on the employer, and governance barriers exist, which prevent professionals from working across services/organisations.

Some local initiatives use a cross-sector multi-professional model to support pharmacists in their practice learning. Devon's Teach and Treat aims to address the barriers associated with accessing a DPP from an external organisation. Pharmacists carry out their 90 hours of supervised practice hosted by a DPP from another setting, including an acute trust, urgent care treatment centre or GP surgery. This has been a successful initiative, with funding for Teach and Treat available nationally through a bidding process.[58]

Funding for training

The ambition to expand the independent prescribing workforce creates high demand for funded training places. Locally, organisations are consistently using their funding allocation for independent prescribing course places each year and local leads in our focus groups suggested that the demand for training twice outweighs the funding available. This creates delays in access to training, making it harder to manage and replenish the local workforce.

Scarcity of funding creates competition to access funded places and we heard that this is a particular challenge for allied health professionals. To combat this, some local non-medical prescribing policies outline a robust candidate selection process, including a panel interview and a maths test. Anecdotally, we heard of allied health professionals losing out on funding to nurses. Nurses can have a wider scope of practice, being able to prescribe controlled drugs, and therefore are seen to bring most benefit to employers, services and patient care.

Currently, independent prescribing courses cost around £2,000 for the six months of studying. NHS England has introduced additional funding aimed at pharmacists already working in the community setting or employed in general practice.[59] This includes 3,300 fully funded places for the academic year 2025/26 across a number of approved education institutions in England. This is a significant funding stream and should improve equal opportunity to access independent prescribing, particularly in light of changes to the pharmacy undergraduate course, set out in the last section of this chapter. However, access to funding is not consistent across the four countries of the UK. We heard that in Northern Ireland only 50 funded training places are ringfenced a year for community pharmacists to access the course.

Local leads in our focus groups also raised increasing the level of funding for independent prescribing as a priority. They referred to this in the context of both accessing funded independent prescribing training places and funding for designated prescribing practitioners, which can be used to incentivise qualified prescribers to become supervisors. Local leads mentioned that, in some instances, they were notified about funded training places with little notice and that places were oversubscribed. When funding was made available to support DPPs, this was often non-recurrent.

The training pathway: is there capacity and how is it used?

We submitted a Freedom of Information request to 11 universities, spread across the regions in England and also across the other three UK countries (see Appendix A for more details). We requested data on available places on their independent prescribing courses and data on enrolled students, including their profession, the length of time they had been on the register before being enrolled, their funding route and the employment sector they work in. The comprehensiveness and detail of the universities' responses varied. In this section we present an overview of the findings and interpretations of the data (see Table B5 in Appendix B for more details).

Two universities in England provided data on the number of applications they received. The data suggests that the number of applicants relative to the number of places available on independent prescribing courses has increased since 2023, particularly for pharmacists. Although we have limited data, there is some evidence of differences between the four UK countries. In Scotland, the data from one university suggests that all applicants are offered a place on the independent prescribing course. Similarly, in Northern Ireland, while the number of applicants has been increasing since 2020, there is still a sufficient number of places available to meet demand.

Across universities, the vast majority of enrolled students were nurses. The data provided on the length of time on the register suggests that the majority of enrolled students had at least eight years of experience before entering the course. Conversely, we received data from two pharmacist-only courses and across the most recent cohorts a significant majority of the enrolled pharmacists had between one and three years of post-registration experience. This difference likely reflects the changes made to course entry requirements for pharmacists.

Notably, the data on the sector that enrolled students were employed in varied across universities (see Table B5 in Appendix B). This suggests there are regional differences in terms of where the demand for independent prescribers is, perhaps linked to local population needs or other local factors.

The proportion of enrolled students who accessed the course through NHS funding was consistently high across universities. Where universities provided complete data, the findings suggest that course completion is high across all professional groups, with low attrition rates, and has remained consistently high over time.

Prescribing training within pre-registration pharmacist training

In 2021, the General Pharmaceutical Council (GPhC) introduced new standards for initial pharmacist education and training.[60,61] These changes will allow pharmacists completing their accredited four-year Master of Pharmacy (MPharm) degree to independently prescribe from the point of registration. To reflect these changes, the new standards have a greater focus on diagnostic and consultation skills, risk management and professional judgement.

The reform also includes the addition of a foundation training year with strengthened supervision. During this training year, individuals must undertake at least 90 hours of supervised practice, with a focus on prescribing. The first cohort will graduate from their MPharm degree and start their foundation training year in 2025/26 and will achieve their independent prescribing annotations in September 2026, entering the workforce as independent prescribers.

One of the significant changes to course content for the new MPharm degree is the increase in clinical placements compared to the previous undergraduate pharmacy degree. Placements have expanded in terms of both duration of time spent on placements and the variety of placements made available to trainee pharmacists.

However, long-term funding is needed to secure these placements.[62] Currently, pharmacy placement providers in England receive less funding than providers in Scotland and Wales – an estimated £20 per day per student in England compared to £120 in Wales and £150 in Scotland.[63]

Key questions remain around who will supervise the future cohort. While

the number of pharmacists who are independent prescribers is growing, the pharmacy workforce is relatively inexperienced in prescribing, with roughly two thirds of independent prescribers having under five years of experience in prescribing. In comparison, current independent prescribers usually have years of experience working in their chosen area of practice. Notably, NHS England has previously supported fully funded training provided by ProPharmace for pharmacists wanting to take up the role of designated prescribing practitioners.[64]

Beyond strengthened supervision, the new MPharm cohort will need specific continuing professional development and education within their chosen area of practice.

5 Governance, regulation and assurance for independent prescribing

In this chapter we describe the oversight of independent prescribing and where the core responsibilities sit within the system. We discuss the role of the regulatory bodies, focusing on the revalidation process for independent prescribers. We highlight the important role of clinical governance at local and organisational levels and outline the support and assurances available to independent prescribers in practice. We also consider some of the challenges around access to both supervision and continuing professional development.

Key findings

- The governance and regulation of independent prescribing is complex and lacks clarity of responsibility.
- There is a risk of deskilling for independent prescribers who do not use their prescribing rights in practice. There was consensus among our stakeholders that additional assurances are needed for independent prescribers to ensure those who do not prescribe often are up to date on their knowledge, competencies and skills.
- The employer holds significant responsibility. At a local level, governance can be more challenging for organisations that employ independent prescribers across multiple settings and specialities.
- Assurances take a competence-based approach. Stakeholders strongly emphasised the importance of all independent prescribers having a clearly defined and recorded scope of practice, outlining what they are competent to prescribe in.

- Access to structured supervision is limited, particularly in community pharmacy settings. We repeatedly heard that informal support was accessed and there are clear disparities in the support available across settings.

- There is evidence that access to continuing professional development (CPD) is challenging, leading to limited opportunities to maintain and improve competence. A lack of protected time is a fundamental barrier to accessing CPD.

How is independent prescribing governed and regulated in the UK?

The governance and regulation of independent prescribing is vast and system wide. It extends across to professional regulators, professional bodies, local employers/organisations and independent prescribers (see Figure 5). Prescribing legislation (see page 39) and the Royal Pharmaceutical Society's competency framework underpin this structure.[3]

Figure 5: The integrated prescribing system

Source: Based on: Association for Prescriber Conference 2025. Presentation titled Regulatory and Policy Developments in Prescribing. Presented by Matthew Clayton, Policy Lead at HCPC.

The regulatory responsibilities for independent prescribing sit with the individual regulators for each profession: the Health and Care Professions Council (HCPC), the Nursing & Midwifery Council (NMC) and the General Pharmaceutical Council (GPhC). Their responsibilities for independent prescribing include:

- setting standards for training and education
- accrediting courses
- annotating professionals as independent prescribers on the register once they have qualified.

All regulators have adopted the Royal Pharmaceutical Society's competency framework[3] as their standards of competency for independent prescribing practice. This framework reflects the core competencies required of all independent prescribers. It is generic and intended to be contextualised to different settings, professions and levels of expertise.

The role of the regulatory bodies

Revalidation

Revalidation allows health care professionals to maintain their registration with their regulatory body. Requirements differ between regulators (see Table B3 in Appendix B), but professionals must provide evidence of how they meet the standards the regulator has set out. This includes demonstrating that they have up-to-date knowledge and skills and have maintained competency within their scope of practice. Regulators will verify the evidence provided for a random selection of revalidation applications.

There is some variation between the regulators in the extent to which independent prescribing is incorporated into revalidation and return-to-practice processes. The NMC revalidation process is heavily centred around the Code (a set of professional standards and competencies) and ensures that registrants have the knowledge and skills to practise safely and within their scope of practice; this encompasses their practice as a prescriber. HCPC revalidation includes a declaration of meeting the standards

of proficiency for safe and effective practice. We heard that this should encompass prescribing practice.

However, there are no specific additional revalidation requirements for those professionals annotated as independent prescribers. The GPhC does provide guidance which states: "Pharmacist prescribers should make sure that some of their revalidation records directly address their role as a pharmacist prescriber."[65] The NMC and HCPC do not currently provide similar guidance, although we heard that the current NMC review of the Code will consult on further guidance for prescribing.[66]

There was consensus among local leads that the revalidation process could provide stronger assurances that independent prescribers have maintained their competency in prescribing. Concerns were centred around professionals who were not using their prescribing qualification and the risk that this would lead to de-skilling. Stakeholders felt that the responsibility for ensuring competence in prescribing is maintained sits with the regulator and should be better implemented in the revalidation process. Notably, previous research found similar views on strengthening the assurance within the revalidation process for advanced clinical practice.[67]

We also heard from our focus groups the need for more scrutiny on prescribing skills when returning to practice for those individuals who are rejoining the register following a period of not working. This was in the context of nurses and allied health professionals. The GPhC includes guidance for independent prescribers when applying to return to the register. This includes demonstrating updated knowledge and skills in prescribing, achieved through shadowing or training such returning to a prescribing course. The application must also provide details of a prescriber who will act as a mentor for at least one month after returning to practice.

Addressing emerging risks

While there is a system of regulations, professional standards, training requirements and employer oversight in place to ensure that prescribers practise safely (see Figure 5 above), developments and innovations can mean that guidance needs to adapt in order to maintain safety in rapidly evolving areas. For example, the recent rise of digital prescribing and online consultations could create safety challenges, such as in verifying

patient information and ensuring adequate clinical assessment. The GPhC responded to this risk by publishing new guidance in February 2025 for pharmacies providing services at a distance, including online – strengthening safety by requiring identity checks, reliable clinical information and clear two-way communication before prescribing medicines.[68] The NMC has recently introduced similar guidance on remote prescribing for aesthetics, requiring a face-to-face consultation before prescribing non-surgical cosmetic medicines.[28]

Shared clinical records between GPs and community pharmacies are developing, but there are concerns that information on prescriptions from pharmacies and other settings does not get recorded in the patient's medical record, or is not easily accessible.[69] One focus group respondent noted that, in some cases, the prescription may be sent to the practice as a scan, but systems for GP practices to update prescribing records for patients vary.

Advanced clinical practice

Advanced clinical practice is where health professionals work autonomously at a high level of practice. While there are no specific regulatory requirements, there are differences between professional groups in whether individuals are working at an advanced level of practice before accessing an independent prescribing course. For nurses and pharmacists, working at an advanced level is not required; however, for allied health professionals, the recommendations differ (see page 45). Additionally, a number of independent prescribers will complete the independent prescribing module as part of an advanced clinical practice Master's qualification.

The NMC launched a review to consider the additional regulation of advanced nursing and midwifery practice in 2023.[70] A phased approach, expected to take place across a number of years, was decided on within the review, with an agreement to proceed to the development of additional regulations for advanced practice. The regulator has recently developed a set of principles for advanced practice, as the first phase of this approach, aiming to bring consistency and clarity to advanced practice across the UK.[71]

This regulatory approach to advanced practice could have wider implications for independent prescribing as, while some independent prescribers are

advanced practitioners and will fall under this new regulation, this is not the case for all. There is therefore a risk of a two-tiered system.

Additionally, a report commissioned as part of the NMC's review identifies a risk that an inconsistent approach to regulation across the different regulators could have an impact on the public's understanding of the advanced practice role.[67] The same risks could apply to independent prescribing. We know that public awareness of the roles of different professional groups who take part in independent prescribing can be limited, and an inconsistent approach between professions in areas such as revalidation could erode this further. Likewise, we heard in our focus groups that the approach to independent prescribing so far has been 'uni-professional' and that there is a strong argument for moving forward with a multidisciplinary approach.

Clinical governance/local policies

Organisations have their own non-medical prescribing policies, and as part of this research, we reviewed 10 of these policies. Integrated care board policies are aimed at independent prescribers who work in general practice or community pharmacies and are linked to the integrated care board's prescribing budget. Policies at trust level are aimed at all independent prescribers working within the trust.

Table 6 outlines some of the key responsibilities at local and individual levels, defined in the policies we reviewed. The independent prescriber is responsible for ensuring they prescribe within their scope of practice and competencies and maintaining their continuing professional development. Integrated care board policies hold the employer responsible, whereas in trust policies the non-medical prescribing lead holds significant responsibilities, including keeping an up-to-date register of all independent prescribers. The independent prescriber's supervisor also has a more defined role in trust policies.

Previous research suggests there is variability in the implementation of policies, which creates uncertainty and limits confidence.[72] Additionally, local policies are often missing and those that do exist can be restrictive.[24]

The same governance structure encompasses all independent prescribers across professional groups in a local area. However, stakeholders we spoke to in our interviews suggested that therapeutic radiographers are not always embedded in the local governance and funding frameworks. We heard that therapeutic radiographers often have to make individual business cases in order to access funding and work as an independent prescriber in their organisation. This is likely because of the small numbers of therapeutic radiographer independent prescribers, meaning organisations have less exposure to the role (see the subsection 'Allied health care professionals' in Chapter 2).

We heard a strong consensus from local leads that the governance of independent prescribing is more challenging in a large trust that covers community and mental health across a number of different specialist providers. In particular, they felt that there was a lack of clarity on where the new prescribing pharmacist cohort (MPharm) will sit within governance structures. We heard that some organisations have planned to implement the new cohort under the existing governance structures for independent prescribers. However, there was no clear consensus on this across organisations.

There could be scope to adopt one guidance document nationally. In the North West of England, a recommendations and principles document on the scope of practice for the new MPharm cohort has been developed. Although it is notably focused on acute care, we heard that this guidance is being adopted in other regions in England.[73]

Table 6: Key responsibilities outlined in integrated care board and trust policies on non-medical prescribing

Responsibilities	Independent care board	Trust
Employer	• Independent prescriber has the skills and knowledge necessary to carry out their role within their area of competency • Assurance to Practice and Scope of Practice Agreement form • Job description identifies scope of practice as an independent prescriber • Individual meets the criteria to enter course • Independent prescriber has a DPP in place	• Training pathway process • Job description identifies role as an independent prescriber
Independent prescriber	• Remaining up to date in field of prescribing and on national and local guidelines • Full responsibility and accountability for clinical assessments • Only prescribing within area of competence and scope of practice • Using the Royal Pharmaceutical Society's competency framework and self-assessment tool when updating scope of practice • Ensuring engagement in CPD and maintaining an up-to-date portfolio • Ensuring patients understand the independent prescribing role • Reviewing approval to practise form annually • Reviewing and monitoring prescribing data	• Prescribing within scope of professional competence and scope of practice • Undertaking regular supervision • Ensuring scope of practice form is completed and up to date • Keeping up to date with CPD and maintaining a portfolio • Acting in accordance with trust policies, legislation and best-practice guidance • Attending additional training organised by the trust • Keeping an accurate record of prescribing practice • Completing a professional development review annually

Responsibilities	Independent care board	Trust
Supervisor	• Agreeing scope of practice with independent prescriber • Verifying that independent prescriber is competent to safely and effectively prescribe • Actively monitoring CPD portfolio at agreed intervals	• Being available for regular supervision • Using the Royal Pharmaceutical Society's competency framework within clinical supervision and ensuring independent prescribers achieve the competencies • Regularly attending trust non-medical prescribing support meetings
Non-medical prescribing lead	• Overseeing and implementing policy • Accessing funding and commissioning	• Maintaining an up-to-date register of all independent prescribers • Recruitment and selection for undergoing training course • Ensuring all staff put forward for an independent prescribing course meet the requirements • Clinical governance • Monitoring and auditing prescribing practice

Source: Nuffield Trust analysis of local non-medical prescribing policies

Assurances for safe prescribing practice

Assurances for safe prescribing practice mainly exist at the employer level and are outlined in integrated care board and trust non-medical prescribing policies. Independent prescribers are responsible for maintaining their skills, knowledge and competency to prescribe safely.

There are a number of different assurances in place and, while there is some variation between organisations, most assurances include:

- a scope of practice agreement, which includes providing evidence of competence to prescribe within an identified scope, usually completed with the independent prescriber alongside their supervisor and then approved by the organisational lead on independent prescribing – the form is then updated at regular intervals (every one to two years)

- a portfolio detailing prescribing practice and completed continuing professional development
- regular monitoring of prescribing data, including audits
- regular supervision and an annual appraisal process with a supervisor.

These assurances are essential for enabling safe practice. Defined areas of competency, such as scope of practice forms, encourage competent and confident prescribing.[24,74] Across our focus groups, local leads emphasised the importance of independent prescribers having a clearly outlined prescribing area and limit of competency. However, stakeholders did discuss the tension between defining a robust scope of practice and still maintaining the knowledge and competencies to be able to safely review all medications and de-prescribe. As the prevalence of co-morbidity increases, de-prescribing and addressing this tension will become increasingly important (see page 65).

In Wales, there are consistent standards for assurances across the country. Wales identified the need for guidance to support independent prescribers on how to evidence their competence to prescribe. In response, Health Education and Improvement Wales developed standards for the competency assurance of independent and supplementary prescribers.[75] The standards are aimed at both independent prescribers and their employers. For independent prescribers, the standards include:

- self-assessing competency annually against the Royal Pharmaceutical Society's competency framework[3]
- an annual declaration of competence to prescribe
- maintaining an ongoing competency portfolio
- an annual declaration of scope of practice
- a prescribing appraisal every three years.

What support is there for independent prescribers?

As outlined in the section above, regular supervision in practice is a key assurance that independent prescribers have the competencies to prescribe safely. Supervision also acts as a means of support for independent prescribers, providing clinical oversight and improving confidence, particularly when first undertaking an independent prescribing role. Support and supervision should be maintained throughout independent prescribers' careers and should come alongside access to continuing professional development.

Support for newly registered prescribers

There is evidence of a lack of self-confidence when independent prescribers are annotated on the register and start their first prescribing role.[74] Newly qualified independent prescribers would benefit from support to build confidence in the role – a lack of support can have an impact on their development.[24]

We heard in our interviews that it can take up to six months after completing an independent prescribing course before gaining the authority to prescribe. This includes the time taken to be annotated on the register and for the employer to complete the relevant administration for the prescriber to enter the prescribing system. We heard views that within this time, independent prescribers could lose the confidence and skills they built up during their training. Stakeholders also provided specific examples of delays in access to prescriptions pads. This concern is reflected in the literature, with one study identifying that these delays can lead to an erosion of confidence.[76]

During the transition period into a prescribing role, there is evidence of a lack of support, with independent prescribers relying mainly on informal support rather than supervision.[74] We heard a strong consensus in our interviews and focus groups that being part of a multidisciplinary team offered more opportunities for stronger supervision and support.

Participants in our focus groups identified that for individuals working in the community and in new areas of prescribing, there is limited support and supervision available. This leaves this cohort of prescribers vulnerable, it could demotivate commissioners from expanding the prescribing role into new areas of practice and it may disincentivise prescribers from working in these areas.

We heard an argument that foundation-year medics had better support structures in place around prescribing compared to newly qualified independent prescribers. Some organisations do offer more formalised supervision and support, such as a preceptorship period of six months following qualification. However, across organisations, there is limited evidence of structured supervision and support available when entering a prescribing role. Moreover, within our job advert review, information on the supervision available within roles was limited.

In our focus groups, we heard varying approaches to supervision for the new cohort of prescribing pharmacists. This included an 18-month preceptorship programme, potentially limiting the medications that can be prescribed during this period. However, it is clear that, locally, these plans are still being finalised, similar to the governance plans for this cohort as outlined earlier in this chapter. Stakeholders consistently identified the new MPharm independent prescribers to be the most vulnerable group of new independent prescribers. There is a risk that a lack of consistency across organisations on support structures for the new pharmacists will exacerbate this vulnerability.

Maintaining access to support throughout a prescribing career is essential to improving and ensuring competence.[77] This can include clinical supervision and continuing professional development opportunities. A team approach to prescribing is a significant enabler for good prescribing practice. The literature also emphasises the role that peer support can play in building confidence, particularly around resisting pressure from patients to prescribe medicine.[78] We heard in our focus groups that most prescribing in hospitals is collaborative within a multidisciplinary team and that, generally, professionals in hospitals have better access to support and supervision throughout their prescribing career.

The increase in the prevalence of multi-morbidities in the population means the number of complex cases that independent prescribers will see in their day-to-day practice will increase. Previous research in general practice identified uncertainty in clinical decision-making for complex cases.[72] Similarly, in the focus groups we heard that the rise in co-morbidities creates a need for independent prescribers to have a broad knowledge base in prescribing and de-prescribing. This highlights the need for ongoing support so that prescribers can navigate these more complex cases.

Continuing professional development

Continuing professional development (CPD) is an essential part of maintaining and improving knowledge and competency in prescribing. It can include attending conferences, participating in independent prescribing support groups, self-directed learning and participating in research.

CPD is important for assurances at an organisation level and in the professional revalidation process. The vast majority of organisation-level policies we reviewed required CPD to be documented in portfolios or workbooks and to be reviewed at least annually. Organisational policies clearly outline that CPD in independent prescribing is the responsibility of the individual prescriber. However, we did hear examples of organisations working to improve CPD opportunities to upskill current independent prescribers. This included actively looking at the national CPD budget and how to use this for training and education, and ensuring professionals are up to date on guidelines.

Access to CPD is a challenge consistently identified in the literature across professional groups. The prescribing course is generic and not all individuals undertake additional training in their area of practice. CPD needs may therefore vary significantly depending on job role and education. For example, the literature suggests a stronger need for CPD in pharmacology for nurses, whereas prescribing policies for pharmacists was identified as a key area.[47,78] Inadequate CPD is also a challenge for physiotherapists.[21]

The literature identifies a frustration that there are limited learning opportunities to maintain and improve competence[77] and a suggestion that CPD is often not tailored to needs.[74] Education providers should

consider developing the content of CPD programmes to help meet these unmet needs.[76]

A lack of protected time for CPD is a significant barrier to undertaking learning. Recent data suggests that more than a quarter of pharmacists working in hospitals in the UK do not have access to protected learning time.[79] When reviewing policies, we only found one example of an organisation explicitly offering protected time for CPD. Furthermore, only one job advert we reviewed offered this.

6 Discussion

This report has explored the current and future direction of the independent prescribing workforce in the UK health care system. In this chapter we draw together the main findings, discuss differences across the UK and consider cross-cutting themes.

Main findings

Independent prescribing by non-medical professionals is now established in the NHS across the UK, with independent prescribers forming 24% of the prescribing workforce. Policy-makers recognise how independent prescribing can contribute to delivering improved care for patients, as part of a broader shift to developing the scope of roles in the workforce, including advanced clinical practice roles.

Since independent prescribing was first introduced in 2002, there has been an expansion in terms of which professions can prescribe, what they can prescribe and the numbers of staff who prescribe as part of their roles. This is set to continue, with all newly qualified pharmacists being able to prescribe from September 2026.

Across all four countries of the UK, national policy has focused on independent prescribing by pharmacists. Individual allied health professions have been seeking to expand their prescribing rights, but this has resulted in differences between professions in their scope of practice. Independent prescribing by nurses is increasingly subsumed within the development of policy for advanced clinical practice.

Given that several allied health professions are seeking expanded roles in prescribing, local service providers and local and national commissioners told us that they are seeking to establish more consistent independent prescribing services, which would enable prescribers to fully use their prescribing qualification, and support patients' greater access to medicines.

However, we also found that current arrangements for funding, supervision and regulation may not be fit for purpose as the independent prescribing workforce expands. It is also unclear where responsibility sits for workforce planning, with some prescribers not being able to use their skills and also there is high demand for access to training.

We found that the training pipeline is fragile: funding to cover both training and the clinical oversight required for trainees is not assured and there is high competition for training places between individuals. The gap between completing training and being in a role where prescribers can use their qualification undermines their confidence to use the qualification.

There are also a range of practical challenges with extending independent prescribing and integrating it into clinical roles and existing services. These have an impact on the extent to which independent prescribers can apply their knowledge within existing NHS roles, and whether other staff and patients and the public accept independent prescribing. In all settings, there are barriers to independent prescribers using their skills within their roles. In community services and community pharmacy, there are additional challenges with limited opportunities for clinical supervision and access to support. Gaps in data collection about the independent prescribing workforce mean that it is not clear to what extent staff are using their skills.

The expansion of independent prescribing has occurred across all four UK countries, and participants in our research from Scotland and Northern Ireland identified similar challenges to those in England. However, there are also policy differences between countries and lessons from implementation from which each country could learn. For example, Scottish stakeholders in our research viewed the national commissioning of community pharmacy in Scotland as enabling Scotland to develop a more consistent approach, which has benefits for service providers, pharmacists and patients and the public.

Cross-cutting themes

Policies to enable independent prescribing sit alongside a number of other **workforce policies**, which have an impact on the role of the relevant

professions. While these policies broadly have shared aims – to enable clinical staff to provide more streamlined care for patients, and to manage growing demand for health care and the increasing prevalence of multi-morbidity – there are gaps and inconsistencies in prescribing authority between professions, which can make implementing services challenging in practice. Nurses have been able to be independent prescribers for the longest, and can prescribe an increased number of controlled drugs compared to allied health professionals, for example. The forthcoming NHS 10 Year Workforce Plan for England is expected to continue to develop advanced clinical practice roles, but it is not clear whether the development of independent prescribing for nurses outside of these roles is anticipated. Important policy developments – such as the move to strengthen neighbourhood health services – will require wide use of independent prescribing skills, yet we have found that the greatest challenges to independent prescribing are in community settings.

There are **differences between professions** in their scope of practice, pre-training experience and qualification requirements, which have developed on a profession-by-profession basis. However, different professions attend the same training courses, and the content that universities provide is the same. This can be a challenge for service delivery, as within community settings the NHS is increasingly developing service models where staff are working in multidisciplinary teams and taking on core roles in patient care that depend on shared clinical skills. International evidence on shifting care from hospitals to community indicates that this requires system-wide changes in workforce.[80]

From September 2026, **pharmacists will become independent prescribers when they qualify**. While this will support the expansion of Pharmacy First policies in primary care, it will take time for prescribing roles to be established. Newly qualified pharmacists who can prescribe will also be working alongside existing pharmacists, many of whom are very experienced but are not prescribers, and so cannot provide supervision for prescribing activity. This introduces potential challenges for organisations' delivery services, as well as for regulators and professionals themselves. Across a range of services, we heard that there are challenges for prescribers if they are the only prescriber in their service or team. For community pharmacy, there is a significant gap between reality and the ambition to increase the number of active independent prescribers.

Developing **sustainable funding** models for independent prescribing is a challenge and this has an impact on all aspects of independent prescribing. There has been specific funding for implementing independent prescribing within local areas, such as the Pathfinder projects in community pharmacy in England, but this funding has now come to an end. Access to funding for training is piecemeal and fragmented, and does not support the full costs of training – such as clinical supervision and continuing professional development (CPD). Without sustainable funding, local areas cannot ensure there are roles available for professionals with independent prescribing qualifications, and this leads to trained staff not using their skills within NHS-funded services.

The **regulatory framework** for independent prescribing operates at the level of professions. Legislation is needed to enable changes to professions' prescribing rights, but this has been slow to come into operation, such that legislation is generally not keeping up with either NHS workforce policy or professional ambitions. The long history of independent prescribing demonstrates the slow timescale from assessing the safety and effectiveness of expanding prescribing rights within professions and to new professional groups, to introducing legislation. And further delays to implementing legislation and independent prescribing policies may well arise given the significant change occurring in the NHS, at the centre – such as the abolishment of NHS England – and locally. This will reduce capacity for work on this issue, and is likely to lead to independent prescribing being a lower priority relative to other policy areas.

There are also gaps in the **current regulatory approach**. There are no additional revalidation requirements for independent prescribers, and data is not collected on whether or not individuals are using their prescribing skills. In particular, the largest group of independent prescribers is nurses, but it is unclear the extent to which they are using their skills. Within community pharmacy, prescribing under the Pharmacy First scheme includes the tracking of antibiotic prescribing.11 But beyond this, there is a need for better monitoring across the board on the prescribing patterns of independent prescribers, including the cohort of newly qualified pharmacists, and the impact of the latter on levels of prescribing overall. This would enable a better understanding of the balance of risks and benefits from widening prescribing roles in different settings. For example, concern has been raised that the

payment mechanisms for community pharmacists, where there is a financial incentive for pharmacists to prescribe, could be encouraging over-prescribing, and this needs to be monitored.[18]

For England, where community pharmacy **commissioning** is locally led, within the framework of a national contract, the change in scope and function of integrated care boards is likely to have an impact on the capacity and strategic oversight of independent prescribing at a local level. At the same time, there is scope for independent pharmacists to have a greater role in neighbourhood health teams. This could result in more variation between local areas in terms of opportunities for community pharmacists to use their ability to prescribe. While this could enable local areas to develop services in response to population need, it would require careful communication to the public, so that they know what services are available where.

Independent prescribing could be of great benefit in support of an ageing population and the increasing prevalence of people with long-term conditions. But the role of independent prescribers in **medicines reviews and de-prescribing** could be strengthened. Medicines management needs to address the risk of polypharmacy (where an individual is taking multiple medicines) and needs independent prescribers who have skills in de-prescribing. Independent prescribing training and protocols for practice need to support this, with a stronger focus on de-prescribing.

In the next chapter we outline recommendations to improve the benefits of independent prescribing, and address the risks identified. This includes opportunities to learn from differences in how independent prescribing has been implemented across the UK.

7 Recommendations

The Department of Health and Social Care and, where relevant, the health departments of the devolved countries of the UK should consider the steps needed to expand the capacity of independent prescribing in the community. This would help to build a workforce capable of delivering neighbourhood health, the shift of care from hospitals to community settings and ambitions for community pharmacy. We recommend the following:

1 Incorporate independent prescribing into the upcoming NHS 10 Year Workforce Plan for England. This should focus on how to better integrate independent prescribing across multiple settings, and the scope to improve the consistency of independent prescribing across allied health professions. This would support multidisciplinary teams' community and neighbourhood working. The plan should explicitly outline what roles independent prescribers will be expected to have within neighbourhood teams, including the role independent prescribers can play in managing patients with multiple long-term conditions. It should also consider providing more detailed modelling of the Master of Pharmacy (MPharm) pipeline into the workforce, ensuring that required supervision is considered within this.

2 Consider the funding and support needs for the entire training pathway. This should include addressing the barriers to accessing a designating prescribing practitioner (DPP). Such actions could involve, for example, assessing the costs and benefits of funding training for DPPs in the community. This is needed to develop supervision capacity and enable the development of prescribing services in line with the intended shift towards more community services.

3 Consider the balance of incentives for independent prescribing in community pharmacies to ensure that prescribing qualifications are used in the community, recognising resource needs for supervision and support.

4 Commission an evaluation of the effectiveness and cost-effectiveness of independent prescribing across different settings. This should include assessing the impact of an increase in independent prescribers on the NHS wage bill, taking account of the Agenda for Change pay bands of these roles.

5 Design an independent prescribing monitoring system, building on existing data sources, with support from employers to collect data. This should include national data collection and publication covering:

   a patterns of prescribing among the new MPharm cohort and among nurses to better understand which services these groups are prescribing in, and how well embedded prescribing is within nursing practice

   b antibiotic prescribing rates and ensuring that the risk of over-prescribing is considered within monitoring.

Regional workforce leads should develop well-considered and thorough plans for the independent prescribing workforce, working with integrated care boards and neighbourhoods.

1 The plans should be underpinned by population need and demand for services and consider how independent prescribing can help meet current and future demands. Plans must consider the changing population, in terms of both ageing and an increased prevalence of multi-morbidity, which is leading to more complex prescribing and de-prescribing.

2 The plans must ensure that employers equip independent prescribers with the continuing professional development and guidance required to maintain competent prescribing across the population.

3 The plans must be focused on ensuring that independent prescribers are working within services that require them to use their prescribing qualification in practice – both to ensure that skills are maintained to underpin prescribing safety, and to make the best use of resources for training.

4 The plans must allow for the integration of learning across services. This could include supporting local agreements between services or a

system-wide approach to allow professionals to move across organisations to obtain knowledge, skills and competencies when training.

5 The plans must incorporate supervision, particularly when integrating and developing independent prescribing within a new service. The plans must also address the barriers to accessing supervision in community pharmacy. This should include ensuring that structured supervision is carefully considered and implemented into all job plans and better valuing the supervisor role by providing protected time.

Additionally, the Department of Health and Social Care should clearly outline the number of funded training places available and communicate these figures to regional workforce teams with sufficient notice.

Regulators, employers and professionals must work to develop and maintain a consistent approach to ensure the safety of independent prescribing. This should be a triple responsibility between them, underpinned by regulation. Establishing consistent and robust assurances across professional groups and settings will build public trust in and understanding of independent prescribing, allowing independent prescribing to be more effective and embedded across the health service We recommend the following:

1 Employers should ensure that all independent prescribers have their prescribing evaluated and discussed as part of their annual appraisal with their supervisor/line manager. The appraisal should include a review of the prescriber's scope of practice, address any continuing professional development needs and collect information on how often the individual is prescribing within their role. This annual appraisal will be time effective as professionals can use it to inform revalidation requirements such as providing evidence of continuing professional development. It must be applied across all settings and services, including non-NHS reimbursed services.

2 Regulators should ensure that professionals provide evidence of their role as an independent prescriber when completing the revalidation process. As part of its current review of the Code, NMC should consider requiring additional evidence of competent and up-to-date independent prescribing

practice within the revalidation process. HCPC should strengthen its safety assurances where possible so that they are in line with any changes to the revalidation process that the NMC and the General Pharmaceutical Council (GPhC) make. Specifically, the GPhC must consider the additional oversight needed for MPharm graduates entering the workforce as independent prescribers.

3 Regulators must continue to adapt their guidance and position statements in line with the emerging risks associated with the expansion of independent prescribing in non-NHS reimbursed services.

4 Regulators should support employers to develop a process for collecting data on the use of the prescribing qualification in practice from their registrants, including:

   a whether the professional is currently working in an independent prescribing role

   b their prescribing patterns, such as how often they use their prescribing qualification

   c what setting/services they work within.

   Data collection should be used to inform national monitoring of independent prescribing practice.

5 Regulators should adopt a process for the formal removal of an independent prescriber's annotation on the register after a period of time not prescribing in practice. This could be linked to the revalidation process by requiring registrants to provide evidence that they are competently using their prescribing qualification. Alongside these changes, regulators should develop more formalised return-to-practice pathways for professionals still on the register but re-entering a prescribing role. The GPhC's current return-to-practice policy for independent prescribers could inform this.

Appendix A: Methodology

This research took a mixed-methods approach and aimed to be UK wide, incorporating findings from across the four countries of the UK. The research took place between September 2025 and January 2026.

Literature review

We undertook a literature review of independent prescribing in the UK, focusing on the participation of independent prescribers in the workforce, training and education, and policy direction. The HSMC Knowledge and Evidence Service at the University of Birmingham conducted the search for papers. It searched across the MEDLINE and CINAHL databases from 2015 onwards, limiting the search to UK-only studies. The final search returned 590 papers. We reviewed the titles and abstracts of these papers and requested 63 for full-text review. After reviewing the full texts, we extracted key findings from 38 papers, excluding the remainder from our review. We carried out data extraction based on the key themes we had identified.

Policy analysis

We carried out a review of national policy documents relevant to independent prescribing, including those on community pharmacy and ambitions for allied health professionals. This review included documents that professional bodies and devolved-nation health boards had published. We also reviewed relevant standards, guidance and competency frameworks that regulators and the Royal Pharmaceutical Society had published.

As part of our review of local governance, we looked at five non-medical prescribing policies that integrated care boards had published, and a further five that NHS trusts/foundation trusts had published. Data extraction included information on defined responsibilities and safety assurances.

We also reviewed six university courses, collecting information on entry requirements, course content and assessment.

Job adverts review

In October 2025, we carried out a search of NHS Jobs, with search terms that included 'independent prescriber' and 'non-medical prescriber'. We reviewed 12 job adverts, extracting information on role overview, entry requirements and access to supervision and continued professional development. Notably, not many roles included an NHS Agenda for Change pay banding, but for the seven that did, all roles were band 7 roles.

Data analysis

We analysed publicly available data and data we requested from regulators. In each case, we requested the most recently available data from the regulators. This included:

- publicly available and data requested from Nursing & Midwifery Council (NMC) data on the number of nurses and midwives with an independent prescribing annotation on its register in March 2025
- publicly available General Pharmaceutical Council (GPhC) data on the number of pharmacists with an independent prescribing annotation on its register in March 2025
- data requested from the Health and Care Professions Council (HCPC) on the number of allied health professionals with an independent prescribing annotation on its register in November 2025
- data requested from the Pharmaceutical Society of Northern Ireland (PSNI) on the number of pharmacists on its register with an independent prescribing qualification in March 2025

- publicly available NHS Business Services Authority prescribing data on the number of prescribers in primary care in March 2025 – this dataset also provides other information on the prescribers, including their profession and place of work

- publicly available NHS England data on the primary care workforce in March 2025.

In November 2025, we submitted a Freedom of Information request to 11 universities across the UK. We requested a range of data relating to the students enrolled on their independent prescribing courses. This included course attrition rates, demand for course places and the professional experience of enrolled students. Seven universities were able to respond to our request within the timeframe of this research.

Stakeholder engagement

We carried out interviews with key stakeholders, discussing the future policy direction for independent prescribing, access to training and participation in the workforce. The stakeholders we spoke to included:

- Department of Health and Social Care
- NHS England
- General Pharmaceutical Council
- Health and Care Professions Council
- Association for Prescribers
- Royal Pharmaceutical Society
- Royal College of Nursing
- Chartered Society of Physiotherapy
- Royal College of Podiatry
- College of Paramedics
- Society of Radiographers
- National Voices.

In December 2025, we held three focus groups. Participants included local leads for independent prescribing at integrated care boards or NHS trusts/foundation trusts across England. We also had participants from

Scotland and Northern Ireland, and invited input from Wales. The focus groups aimed to understand the local perspective, and local priorities and implementation challenges.

Appendix B: Additional analysis

This appendix consists of additional policy analysis and charts.

The history of independent prescribing

Independent prescribing in the UK has developed over time as the NHS has sought to improve patient access to medicines and make better use of the health care workforce.

It began in the early 2000s, when **supplementary prescribing** was first introduced, allowing trained nurses and pharmacists to prescribe medicines in partnership with a doctor under a Clinical Management Plan. As confidence with the evidence grew, the government expanded this by allowing **independent prescribing** for these professions in 2006, with full access to the British National Formulary, enabling them to diagnose and prescribe autonomously within their scope of practice. Over the next decade, independent prescribing rights were gradually extended to other professions – including optometrists, physiotherapists, podiatrists, therapeutic radiographers and paramedics – through a series of consultations and legislative changes.

However, competing priorities for government and the NHS have affected the development of independent prescribing. At the time of the restructure of NHS England through the Health and Social Care Act 2012, there was a significant three-year gap when no reports or strategic documents relating to independent prescribing were released by a government body.[81]

Today, independent prescribing is well established in the NHS, but the landscape is still developing, with national ambitions for expanding prescribing rights further.

Table B1 presents a timeline of the history of independent prescribing in the UK.

Table B1: Timeline of the development of independent prescribing rights

Year	Key developments	
1986	Cumberlege Report	Recommended that community nurses should be able to prescribe, as part of their everyday nursing care, from a limited list of items
1989	Crown Report	Endorsed nurse prescribing and recommended which items nurses should prescribe and the circumstances in which they should prescribe them
1992	Medicinal Products: Prescriptions by Nurses etc Act	Legislation enacted to allow community nurses to prescribe from the Extended Formulary for Nurse Prescribers
1994	First prescribing pilots	First prescribing pilots by nurses and introduction of Nurse Prescribers' Formulary
1998	Secretary of State announced intention to extend nurse prescribing more widely	District nurses and health visitors became legally able to prescribe from the Nurse Prescriber's Formulary
1999	Crown II Report	Recommended that other health professionals should be able to prescribe in specific clinical areas, where this would improve patient care and safety
2001	Health and Social Care Act 2001	Laid the foundation for **supplementary prescribing** – introduced in 2003 for nurses and 2004 for pharmacists
2002	Introduction of independent prescribing	Nurses allowed to train as **independent prescribers** but with a restricted formulary – this included a list of prescription-only medicines for specific conditions

Year	Key developments	
2006	Expansion of independent prescribing	Nurses and pharmacists allowed to train as independent prescribers and given full access to the British National Formulary (BNF), putting them on par with doctors in relation to prescribing capabilities
2008	Optometrists	Gained independent prescribing rights
2012–18	Access to controlled drugs	Gradual extension allowing independent prescribers to prescribe certain controlled drugs
2013	Physiotherapists and podiatrists	Became eligible to train as independent prescribers
2016	Therapeutic radiographers	Permitted to become independent prescribers
2018	Paramedics	Gained independent prescribing rights (excluding most controlled drugs)
2020	Allied health professional consultations	Consultations took place on extending prescribing responsibilities for physiotherapists, podiatrists, paramedics and other allied health professionals
2021	Commission on Human Medicines (CHM) recommendation	To enable diagnostic radiographers to become independent prescribers (legislation change still pending)
2023	Paramedics	Legally permitted to prescribe a range of controlled drugs as independent prescribers
2025	Government consultation	On extending medicines responsibilities for paramedics, physiotherapists, diagnostic radiographers and operating department practitioners
2026	Pharmacists	From 2026, all newly qualified pharmacists in the UK will be registered as independent prescribers

National ambitions for independent prescribing in the community

England

The *NHS Long Term Workforce Plan*, which NHS England published in June 2023,[4] included an ambition for all newly qualified pharmacists to become independent prescribers from 2026, which will shorten the time it takes for pharmacists to prescribe independently from around eight to five years from the start of training.[74] The plan also indicated that, through regulatory and legislative reform, pharmacy technicians will be able to supply medicines through Patient Group Directions (written instructions to help administer medicines to pre-defined patient groups). For allied health professionals, the plan committed to enhancing the scope and reach of their roles to help manage demand, through increasing the number of advanced practitioners and independent prescribers. Alongside that, NHS England committed to supporting 3,000 pharmacists who have not yet completed an independent prescriber course to gain the qualification to prescribe. For 2025/26, NHS England funded 3,300 places on independent prescribing courses for pharmacists.[29]

There are ambitions for community pharmacy in England that relate to pharmacists increasingly being able to independently prescribe. The *NHS 10 Year Health Plan* for England[23] drew attention to this as key to the transition of community pharmacy from being focused largely on dispensing medicines to offering more clinical services.[82] The role of community pharmacists in the management of long-term conditions, complex medication regimes, hormonal contraception and prevention through vaccine delivery and certain screening will increase. These expansions in community pharmacy form part of the overarching plan to recover access to primary care.[83] By providing services that, traditionally, GPs would have delivered, they may help to relieve demand on general practice, and reduce inequalities in access.

In England, community pharmacy is commissioned via a national contract, which has a mix of essential elements, advanced elements that are nationally defined but not mandatory, and scope for additional locally commissioned

elements. NHS England launched the Community Pharmacy Independent Prescribing Pathfinder Programme in 2024, which funded 'pathfinder' sites to test models of delivery for pharmacist independent prescribing.[20,30] The aim was to establish a framework for the future commissioning of NHS community pharmacy clinical services in England. The Pathfinder Programme formally concluded in December 2025,[84] and in the next financial year NHS England will consult with Community Pharmacy England to determine a possible national service offer. In the meantime, with NHS England funding coming to an end, integrated care boards are required to consider funding local pathfinder sites for existing service arrangements to continue. The *Medium Term Planning Framework*, which NHS England published in October 2025, stated that integrated care boards must introduce prescribing-based services into community pharmacies during 2026/27.[85]

Scotland

In Scotland, there are national plans for independent prescribing that relate to expanding the pharmacist independent prescriber workforce. In recent years, NHS Education for Scotland has increased funding for pharmacist independent prescribing training, with new places funded to meet growing demand across the community, hospital and primary care sectors.[86] All newly registered pharmacists in Scotland will be pharmacist independent prescribers from 2026.[87] This is part of wider plans to enable pharmacists to have a greater role in clinical care, with enhanced recognition as medicines experts and increased roles in public health and wellbeing.[87] Further, the Royal Pharmaceutical Society in Scotland's *Pharmacy 2030* report sets out a vision that all patient-facing pharmacists will have advanced clinical capabilities and be independent prescribers by 2030.[31]

In September 2020, the NHS Pharmacy First Plus service was introduced across Scotland. This service allows community pharmacist independent prescribers to prescribe treatment for a wider range of common clinical conditions than under the original Pharmacy First service.[32] Community pharmacies that sign up with their health board and have a qualified pharmacist independent prescriber can deliver the service and claim remuneration.[88] There is an expectation that all community pharmacies in Scotland will provide a Pharmacy First Plus service by the early 2030s.[32]

Wales

In 2024, the Welsh government published national guidance in the form of *Independent and Supplementary Prescribing in Wales and Standards for Competency Assurance of Independent and Supplementary Prescribers in Wales*.[33,75] These national-level policy documents, aimed at all non-medical prescribers across multiple settings, signal that independent prescribing is a core part of the Welsh NHS workforce strategy.

There is a nationally commissioned Pharmacy Independent Prescribing Service (PIPS) in Wales, which enables patients to see pharmacist independent prescribers within a community pharmacy.[34] The Royal Pharmaceutical Society and Health Education and Improvement Wales recently extended their learning programme, tailored to support pharmacists in Wales to deliver PIPS, to run until at least 2028.[89] As in the other UK countries, all newly qualified pharmacists joining the General Pharmaceutical Council's register from 2026 will be pharmacist independent prescribers. There has been a rapid expansion of independent prescribing across community pharmacies in Wales, and the Royal Pharmaceutical Society has a strategic aim to have an independent prescriber in every community pharmacy by 2030.[35]

Northern Ireland

In Northern Ireland, the Department of Health has an overall ambition to develop non-medical prescribing within the health service to enable health care professionals to enhance their roles and use their skills to improve patient care across a range of settings.[90] Newly qualified pharmacists registered with the Pharmaceutical Society of Northern Ireland will be independent prescribers from 2026. As part of this reform, the Department of Health launched the Experiential Learning programme for pharmacy undergraduates, to provide them with multi-sector clinical work placements.[91] Additionally, the Northern Ireland Centre for Pharmacy Learning and Development is funding 150 places on independent prescribing courses for pharmacists.[36]

There is a long-term strategy for expanding the general practice pharmacist workforce. 'GPP NI 2030 – A Strategy for General Practice Pharmacy in

Northern Ireland' outlines how general practice pharmacists will become "clinical leads for medicines" within general practice teams and they will be independent prescribers and consult directly with patients to review and prescribe medicines.[92]

Longer-term funding has also been secured for the New Models of Prescribing (NMOP) project, which allows prescribers working at interfaces between hospitals and general practice to prescribe medications directly to patients, which can be dispensed in the community.[93] One of the described benefits of NMOP is that it increases care that non-medical prescribers can deliver.

Northern Ireland's *Community Pharmacy Strategic Plan 2030* states that independent prescribing by community pharmacists will increasingly be embedded within services such as Pharmacy First, alongside a progression towards advanced practice roles.[37] Although there is a vision to incorporate independent prescribing into community pharmacy services, there is currently no nationally commissioned independent prescribing service as there is in Scotland and Wales. The strategic plan says that full delivery is subject to funding, contractual arrangements and legislative changes.

Additional tables

Table B2: Extended detail on allied health professions strategies for independent prescribing

Strategy	
The **British Dietetic Association (BDA)** is campaigning for dietitians to gain independent prescribing rights	• The BDA has established a Prescribers Specialist Sub-Group to lead a campaign to advance the dietetic profession from supplementary to independent prescribing rights.[39] • The group's objectives include collecting data to provide evidence that dietitians are prescribing safely and effectively and to influence government policy to support the transition to independent prescribing. • Their proposed strategy is phased: – short term (one to two years): legislative change and training development – medium term (two to five years): rollout for eligible dietitians, focusing on key areas – long term (more than five years): rollout across settings, with monitoring and evaluation.[90]
Joint **#PrescribingNow** campaign across a number of allied health professional bodies	• The #PrescribingNow campaign is a partnership between the BDA, the Royal College of Occupational Therapists, the Royal College of Speech and Language Therapists, the British and Irish Orthoptic Society, the Society of Radiographers, the Chartered Society of Physiotherapy, the College of Podiatry, the College of Operating Department Practitioners, the Institute of Osteopathy and the College of Paramedics.[40] • The campaign calls for the expansion of independent prescribing rights to specified allied health professionals across the four UK nations.
The **Independent Prescribing Rights Proposal Group**	• This is a group of health care professionals from across the UK, directing a proposal to allow allied health professional independent prescribers the ability to prescribe all licensed and unlicensed medications, including schedules 2 to 5 controlled drugs, for any medical condition within their scope of practice and competency (with the exception of diamorphine, cocaine and dipipanone for the treatment of addiction[41]).

Strategy	
The consultation to **extend medicines responsibilities for allied health professions**	• The Department of Health and Social Care ran a consultation from August to October 2025, seeking views on extending medicines responsibilities for four allied health professions:[42] – **paramedics** – extending the list of medicines all paramedics can administer in emergency situations, to include three additional controlled drugs and four prescription-only medicines under exemptions in the Human Medicines Regulations 2012 – **physiotherapists** – allowing them to prescribe four additional controlled drugs beyond the seven already permitted – **operating department practitioners** – enabling them to supply and administer medicines using Patient Group Directions – **diagnostic radiographers** – permitting advanced, enhanced and consultant diagnostic radiographers to train as independent prescribers. For historical context: • In 2020, the Chief Professions Officers' Medicines Mechanisms (CPOMM) programme ran UK-wide consultations on proposals to change medicines responsibilities for eight health professionals, including paramedics, physiotherapists and operating department practitioners.[94] The regulator, the Health and Care Professions Council (HCPC), supported the proposed changes. • A 2021 Commission on Human Medicines review recommended that diagnostic radiographers should be allowed to become independent prescribers.[95] These proposed changes are being re-consulted on under the Medicines and Medical Devices Act 2021 to make the required changes to the UK's post-Brexit legislative framework[94]

Source: Nuffield Trust review of strategy documents

Table B3: Current regulatory requirements for revalidation

	Nursing & Midwifery Council (NMC)	General Pharmaceutical Council (GPhC)	Health and Care Professions Council (HCPC)
Professions	• Nurses and midwives	• Pharmacists	• Chiropodists/ podiatrists • Paramedics • Physiotherapists • Therapeutic radiographers
Revalidation period	• Revalidate every three years	• Revalidate every year	• Revalidate every two years
Revalidation process	• 450 practice hours • 35 hours of CPD, including 20 hours of participatory learning • Five pieces of practice-related feedback • Five written reflective accounts • Reflective discussion • Health and character declaration • Professional indemnity arrangement • Confirmation	• Four CPD records • One peer discussion record • One reflective account record	• Professional declaration • If audited, a complete CPD profile and supporting evidence that CPD meets the standards
Requirements on prescribing annotation	• Nothing specified but revalidation process must be in accordance with the Code	• Some of the above revalidation records should address the individual's role of prescriber	• Nothing specified but the revalidation process must meet standards

Note: CPD = continuing professional development.
Source: Nuffield Trust review of NMC, GPhC and HCPC standards and guidance for revalidation

Table B4: Details on prescribers in primary care, March 2025

	Registrants with an annotation	Number who prescribe in a primary care setting	Active prescribers in primary care as a proportion of registered prescribers	Primary care headcount	Proportion of headcount who are active prescribers
GPs	271,980	48,856	18%	48,941	99.8%
Pharmacists*	17,767	5,248	30%	2,368	N/A
Nurses	56,917	12,148	21%	23,070	53%

Notes: The Prescriber Details dataset drawn on provides information on the number of prescribers actively prescribing in primary care for the month of March 2025, as well as, for example, the profession of the prescriber. The data has been limited to GP practices.

* This includes community pharmacists as well as general practice and primary care network staff, so primary care headcount data is not a suitable denominator.

Source: NHS Business Services Authority, 'Prescriber Details' dataset[96] and NHS Digital, 'General Practice Workforce' data, March 2025

Table B5: Most recent graduated cohort of enrolled students on independent prescribing courses across the UK

Nurses and allied health professionals	Number of students enrolled on the course	Sector employed in	Profession	Length of time on register before being enrolled	Undergraduate training in the UK	NHS funded	Course completion
East of England	>22	Community	Nurses		100%	~80%	~80%
		~58%	~92%				
North West England	>19	Primary care	Nurses	12+ years	91%	94%	85%
		~55%	~75%	~60%			
North East England and Yorkshire	54	Acute trust	Nurses	12+ years	98%	96%	100%
		72%	85%	44%			
South West England*	33	Acute trust	Nurses	8–11 years	91%	94%	85%
		52%	52%	36%			
Scotland	55						
Northern Ireland	89	Hospital	Nurses			92%	91%
		97%	98%				

Pharmacist courses	Number of students enrolled on the course	Sector employed in	Profession	Length of time on register before being enrolled	Undergraduate training in the UK	NHS funded	Course completion
The Midlands**	81		Pharmacists 94%			50%	95%
North East England and Yorkshire	43	Acute trust 60%	Pharmacists only	1–3 years 77%	98%	100%	98%
Northern Ireland	32	Hospital 97%	Pharmacists only	1–3 years 94%	91%	81%	100%

Notes: Data is from the most recent graduate cohort: 2024/25. The table shows the number of students enrolled on the course, the sector the students are most commonly employed in, the students' profession, the length of time the students were on the relevant professional register before being enrolled on the course and the proportion of students who fit within these groups. In some cases, estimates are given due to redaction of data to account for small numbers.

* This course is open to pharmacists as well as nurses and allied health professionals.

** This course is open to allied health professionals as well as pharmacists.

Source: Freedom of Information request responses from the University of Surrey, University of Birmingham, University of Sunderland, University of Liverpool, University of Exeter, Queen Margaret University and Queen's Belfast University.

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