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|---|---|
| **Title:** Consultation Stage Impact Assessment on Extending medicine responsibilities for Paramedics, Physiotherapists, Operating Department Practitioners and Diagnostic Radiographers | **Impact Assessment (IA)** |
| **IA Number:** DHSC IA 9688 | **Date:** 04/08/2025 |
| **Lead department:** Dept. of Health & Social Care | **Stage:** Consultation |
| **Other depts/agencies:** - | **Source of intervention:** Domestic |
| | **Type of measure:** Secondary Legislation |
| | **Contact for enquiries:** prescribingpolicy@dhsc.gov.uk |

## Summary: Intervention and Options

This IA is exempt from RPC referral on the basis that this is an update to technical standards on recommendation from independent advisory bodies.

| **Cost of Preferred (or more likely) Option** (base year = 2025) | | |
|---|---|---|
| **Total Net Present Social Value** | **Business Net Present Value** | **Net cost to business per year** |
| £m tbc | £m tbc | £m tbc |

**What is the problem under consideration? Why is government action or intervention necessary?**

Healthcare services have undergone significant transformation, with highly trained non-medical professionals, including Allied Health Professionals, providing substantial direct patient care independently.
The rules on who can prescribe, administer or supply particular medicines, as well as which mechanisms are used, no longer reflect developments in best practice.
Referrals between some clinicians and doctors no longer follow best perceived practice and may be inefficient. This can include in emergency situations where any delay can have serious consequences.
The issues affect paramedics, physiotherapists, operating department practitioners and diagnostic radiographers.
There is scope to improve processes to reduce burdens on clinicians and improve access and outcomes for patients.
Legislation defines which professions can utilise independent prescribing, exemptions, and patient group directions, indicating that any reform requires government action.

**What are the policy objectives of the action or intervention and the intended effects?**

The objective is to improve patient access to medicines via the professionals best placed to provide them.
This can be achieved by:

- Extending the list of medicines (including controlled drugs) that paramedics can administer in emergency situations using exemptions within medicines legislation;
- Extending the list of controlled drugs that physiotherapist independent prescribers are legally able to prescribe;
- Enabling operating department practitioners to supply and administer medicines using patient group directions (PGDs) [1,2];
- Permitting diagnostic radiographers to train as independent prescribers.

The desired outcomes include better management of NHS capacity (including reducing pressure in primary care), faster care provision, more efficient use of healthcare professional's time, improved patient experience and improved patient

**What policy options have been considered, including any alternatives to regulation?**

Rules for Prescription-Only Medicines are regulatory by nature and set in legislation. Maintaining the status quo is possible but fails to deliver the desired benefits.

The proposed reform comprises independent changes to four professions:

- Extend the list of medicines (including controlled drugs) that **paramedics** can administer in emergency situations using exemptions within medicines legislation.
- Extend the list of controlled drugs that **physiotherapist independent prescribers** are legally able to prescribe.
- Enable **operating department practitioners** to supply and administer medicines using patient group directions.
- Enable **diagnostic radiographers** to train as independent prescribers.

Each of these proposals is treated as a separate option, with the preferred way forward embracing all four.

| | |
|---|---|
| Is this measure likely to impact on international trade and investment? | No |

[1] Please see Annex A.6 for the glossary of key terms.

[2] Patient Group Directions are written instructions for medicines, including certain controlled drugs, to be supplied and/or administered by health professionals to patients who share the same medical condition or other features. They contain information about which health professionals can supply or administer the medicine, which patients they can see, and when they should involve a doctor. PGDs are not a type of prescription.

| Are any of these organisations in scope? | **Micro** Yes | **Small** Yes | **Medium** Yes | **Large** Yes |
|---|---|---|---|---|
| What is the $CO_2$ equivalent change in greenhouse gas emissions? (Million tonnes $CO_2$ equivalent) | | Nil (not applicable) | | |
| **Will the policy be reviewed?** All reforms, if adopted, will be monitored and reviewed (timing tbc). | | | | |

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

Signed by the responsible SELECT SIGNATORY: Karin Smyth Date: 04/08/2025

# Summary: Analysis & Evidence

Overall Summary

**Description:** Assumes adoption of proposals for all four professions

**FULL ECONOMIC ASSESSMENT**

| **Price Base Year** 2025 | **PV Base Year** 2025 | **Time Period Years** 10 | **Net Benefit (Present Value (PV)) (£m)** | | |
|---|---|---|---|---|---|
| | | | **Low:** tbc | **High:** tbc | **Best Estimate: tbc** |

| **COSTS (£m)** | **Total Transition** (Constant Price) Years | | **Average Annual** (excl. Transition) (Constant Price) | **Total Cost** (Present Value) |
|---|---|---|---|---|
| **Low** | tbc | | tbc | **tbc** |
| **High** | tbc | | tbc | **tbc** |
| **Best Estimate** | | | | |

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

Costs are largely unmonetised at this stage.

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

One-off training costs, borne largely by NHS organisations. Larger training costs for diagnostic radiographers. Minimal for paramedics and physiotherapists. Not currently quantified for operating department practitioners.
Administration cost of developing and reviewing patient group directions for operating department practitioners. This would recur every three years under current rules.

| **BENEFITS (£m)** | **Total Transition** (Constant Price) Years | | **Average Annual** (excl. Transition) (Constant Price) | **Total Benefit** (Present Value) |
|---|---|---|---|---|
| **Low** | tbc | | tbc | **tbc** |
| **High** | tbc | | tbc | **tbc** |
| **Best Estimate** | | | | |

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

Benefits are largely unmonetised at this stage.

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

The following benefits are recurring:
Administration cost of developing and reviewing some patient group directions for paramedics and diagnostic radiographers. This cost would recur every three years under current rules.
Reduced need for prescribing referral to medical practitioners.
Reduced delay in providing medication to patients, and hence improved patient experience.
Improved use of clinicians' skill set and workforce efficiency.
Improvement in health outcomes (and associated reduction in longer-term health costs) following from the above.
Possible further indirect improvements (e.g. in ill-health absence).

**Distributional impacts**

The reform is not expected to have a direct distributional effect, but evidence is limited. It may indirectly have an impact if patients with protected characteristics are disproportionately likely to be treated by the four professions using the newly allowed medicines or procedures.

| **Key assumptions/sensitivities/risks** | **Discount rate** |
|---|---|
| The evidence base is limited and varies across the four professions. At this stage the analysis is relatively qualitative but has been quantified where possible.<br>A case study approach has been used to assess the potential impacts of the reform. | |

**BUSINESS ASSESSMENT (Option 1)**

| **Direct impact on business (Equivalent Annual) £m:** | | |
|---|---|---|
| **Costs:** tbc | **Benefits:** tbc | **Net:** tbc |

# Evidence Base

## Problem under consideration and rationale for intervention

1.1. This Impact Assessment evaluates potential modernisation of medicines legislation for four professions: paramedics, physiotherapists, operating department practitioners and diagnostic radiographers. Some of these ideas have been previously consulted on and can be found here. We believe this approach is still valid, and so have updated and adapted some elements of analysis.

1.2. Best practice has now evolved and requires medicines legislation to reflect these new patient pathways. The modernisation of medicines legislation intends to support patient access to prescription-only medicines and alleviate pressure on the NHS, including on primary care. It works to alleviate pressure on clinicians and the wider health service by reducing the need for appointments with additional health professionals just to receive the medicines needed, which can result in unnecessary delays in diagnosis or to start treatment. The reform also intends to streamline care, improve patient experience and take advantage of clinicians' skills.

1.3. Legislation defines which professions can use independent prescribing, exemptions, and PGDs. Any change to this legislation requires government action. There has been consideration that changing legislation poses a risk to drug misuse and patient safety; however, this is assessed to be unlikely. The allied health professions possess extensive knowledge of medicines relevant to their areas of practice. This knowledge is thoroughly integrated into pre-registration education and training programmes, ensuring compliance with the standards of proficiency required for the Health and Care Professions Council (HCPC) registration. The proposed reforms are not expected to impact patient safety and include safeguards around qualifying staff and training. They instead aim to ensure that practice matches the current skills and capabilities of the clinical workforce, delivering benefits to patients in the process.

1.4. **Paramedics** can administer medicines listed within Schedule 17 of the Human Medicines Regulations 2012 for the immediate, necessary treatment of sick and injured persons without the requirement for a prescription, directions of a prescriber or a PGD. Currently, there are medicines that paramedics must administer routinely for emergency care, but they can only do this through using a PGD. To ensure that best-practice medicines can be administered in a timely manner, NHS ambulance services must ensure that as many paramedics as possible have signed the relevant PGDs. This requires significant administrative effort on the part of the ambulance service, and there remains a risk that some paramedics will not be able to administer the required medicines at the required time. Further, following the Manchester Arena Inquiry report, benefits of the provision of analgesia in relieving pain were highlighted.

1.5. **Physiotherapists** have been able to supply and administer medicines for many years, through the use of patient specific directions (PSDs[1]) and patient group directions (PGDs). Physiotherapists working at an advanced level are also able to prescribe medicines for their patients using either supplementary or independent prescribing. Since 2015, physiotherapist independent prescribers in England, Scotland and Wales (and 2019 in Northern Ireland) have also been able to prescribe from a restricted list of seven controlled drugs. However, clinical prescribing practices

[1] Patient Specific Directions are a written instruction to administer or supply a medicine to a named patient who has been assessed by an authorised prescriber.

have since developed, and this list is no longer in line with best practice guidance. Currently, patients under the care of a physiotherapist, who would potentially benefit from accessing any controlled drug to relieve pain not on the current list must make an additional appointment with another health professional (typically a GP). Further benefit could be gained by extending the range of controlled drugs that physiotherapist independent prescribers can prescribe. This will help ensure patients receive the right treatment and at the right time, which includes appropriate pain management.

1.6. **Operating Department Practitioners** (ODPs) are currently able to administer and supply medicines under PSDs. Given the difficulty of anticipating the need for medicines for patients, ODPs often do not have the required PSDs, and so are unable to supply and administer required medicines at the required time. Additionally, there are limitations to the use of PSDs, which require direct input from an independent prescriber for each patient. This leads to unnecessary consultations with other healthcare professionals, which represents an inefficient use of public money and NHS resources and may delay access for patients who require their skills. It also inconveniences patients.

1.7. **Diagnostic radiographers** can currently supply or administer medicines using PGDs or PSDs and can train as supplementary prescribers. To reduce delays in care and ensure timely access to medicines, benefits could be seen from enabling diagnostic radiographers to become independent prescribers of medicines across the UK. The delay in accessing medicines may result in a delayed diagnosis, a lack of timely access to treatment as well as longer-term risks to effective recovery and rehabilitation.

1.8. Government intervention is required to address the modernisation of medicines legislation as it is highly regulated, to maintain patient safety.

## Rationale and evidence to justify the level of analysis used in the IA (proportionality approach)

1.9. There are restrictions within UK-wide medicines legislation as to who can supply, administer and prescribe medicines. Evidence suggests there are potential efficiency gains and improvements to patient experience and health outcomes if certain healthcare professions can prescribe a wider range of medicines[2].

1.10. The expected effect is that most people will continue to be treated with the same medications as currently, but more quickly and efficiently. It is not intended or expected that the reforms would change demand for medicines, only to simplify existing processes or ensure stronger legal clarity on activities already carried out in practice.

1.11. The nature of the costs and benefits is well understood. The main cost, training, is expected to be low for both paramedics and physiotherapists and that assessment has high confidence because only a marginal addition to existing training is required. Training costs for ODPs is expected to be higher, due to the cost of developing PGDs and familiarisation with this process. Training for diagnostic radiographers is expected to be the highest of the four professions, as they do not currently undertake training for independent prescribing.

[2] A comparative case study of prescribing and non-prescribing physiotherapists and podiatrists (2020) Carey et al. BMC Health Services Research (2020) 20:1074 https://doi.org/10.1186/s12913-020-05918-8

1.12. For benefits, uncertainty is greater. The argument that benefits will accrue is very strong, and that they will exceed the costs is also strong. But their absolute size is dependent on uncertain assumptions and influenced by the considerable variation in individual patients. Benefits are also dependent on the new flexibilities being adopted; however, communication with each profession's respective professional body indicates that there is demand for and interest in the reforms. On balance, the analysis has been kept relatively simple.

1.13. Impacts on business are dependent on (1) the degree to which clinicians work in non-NHS settings (believed to be less than 10% of the total (around 30% for physiotherapists), and (2) the degree to which time savings can be converted into additional profit-making activity in the private sector. Given that business costs are expected to be both low and voluntary, the business analysis has been kept high-level.

1.14. These proposals are expected to be beneficial to all stakeholders, potentially significantly so, and that conclusion is not particularly sensitive to the results of the analysis.

## Description of considered options

1.15. The consultation comprises proposals for four professions. These are presented in this impact assessment as four independent options for convenience. The eventual way forward may contain some or all of these in combination, or none, depending on the consultation outcome and other evidence. Each of the four options may also contain sub-options with flexibility around some of the detail.

Option 1: Business as usual/no change

1.16. Maintain the current limitations on prescribing and administration of prescription- only medicines and controlled drugs. This preserves all current processes and requires no action or investment. This option sets the baseline against which any reform can be judged.

Option 2: Amend the Human Medicines Regulations 2012 and the Misuse of Drugs Regulations 2001 (for proposals with controlled drugs implications) to allow independent prescribing, supply or administration in certain specified situations.

1.17. Each situation can be considered on its merits and implemented (or not) on a case-by-case basis. The recommended option would allow:

1. Paramedics to administer three additional controlled drugs under exemptions: lorazepam (by injection), midazolam (by injection) and three forms of fentanyl (oral transmucosal, intranasal, intravenous); and four prescription-only medicines under exemptions: dexamethasone, magnesium sulfate, tranexamic acid and flumazenil.
2. Physiotherapist independent prescribers to prescribe four additional controlled drugs: codeine phosphate (oral administration), tramadol hydrochloride (oral administration), pregabalin (oral administration), gabapentin (oral administration).
3. ODPs to supply and administer medicines using PGDs.

4. Diagnostic radiographers to train to become independent prescribers.

In each case, there will be further criteria and restrictions that must be met, for example with respect to training or experience of the clinician. Full details will be set out in the regulations and accompanying guidance.

Option 2 is the preferred option.

## Policy objective

1.18. The technical objective is to amend the Human Medicines Regulations 2012, and the Misuse of Drugs Regulations 2001 for proposals with controlled drugs implications, to allow independent prescribing, supply and administration of medicines by a wider range of professionals. Such responsibilities would not be compulsory, but clinicians would have greater flexibility to respond to patient needs.

1.19. The objective of the proposed changes is to increase patient access to medicines via the professionals best placed to provide them, whilst being an effective way to manage NHS capacity, including reducing pressure in primary care.

1.20. These objectives can be measured and evaluated through dialogue with external stakeholders within the NHS, the independent sector organisations and at each profession's respective professional body. These conversations would be centred around the:

- Number of patients receiving treatment for the listed medicines.
- Number of referrals for the listed medicines.
- Level of prescribing for the listed medicines.
- Potential time saved in primary care.

1.21. Indicators of success would be:

- Reduced pressure on GPs and the NHS, by removing the need to refer prescribing decisions;
- Reduced costs on NHS time, in the same way as above;
- Improved patient outcomes, by reducing delays and speeding up treatment whilst simultaneously freeing up capacity in the system;
- Improved equality of access to healthcare; and
- Improved patient experience.

1.22. The reforms are not intended or expected to lead to an increase in prescribing, supply or administration of the medicines concerned. The aim is simply to adopt a faster and more efficient way of managing existing demand.

## Summary and preferred option with description of implementation plan

1.23. Subject to the outcome of the consultation, the preferred approach is to implement change for all four professions, with the detail of each to be clarified.

1.24. An implementation plan will be developed in due course, once decisions on the way forward have been taken.

## Monetised and non-monetised costs and benefits of each option

### DETAILED ANALYSIS FOR PARAMEDICS

2.1. The proposed reform would enable registered paramedics to administer three additional controlled drugs under exemptions:

- Lorazepam (by injection)
- Midazolam (by injection)
- Three forms of fentanyl (oral transmucosal, intranasal, intravenous)

and four prescription-only medicines under exemptions:

- Dexamethasone
- Magnesium sulfate
- Tranexamic acid
- Flumazenil

2.2. This should ensure that patients receive timely access to medication, by enabling paramedics to administer medicines indicated by best clinical evidence from a comprehensive exemptions list, without delay.

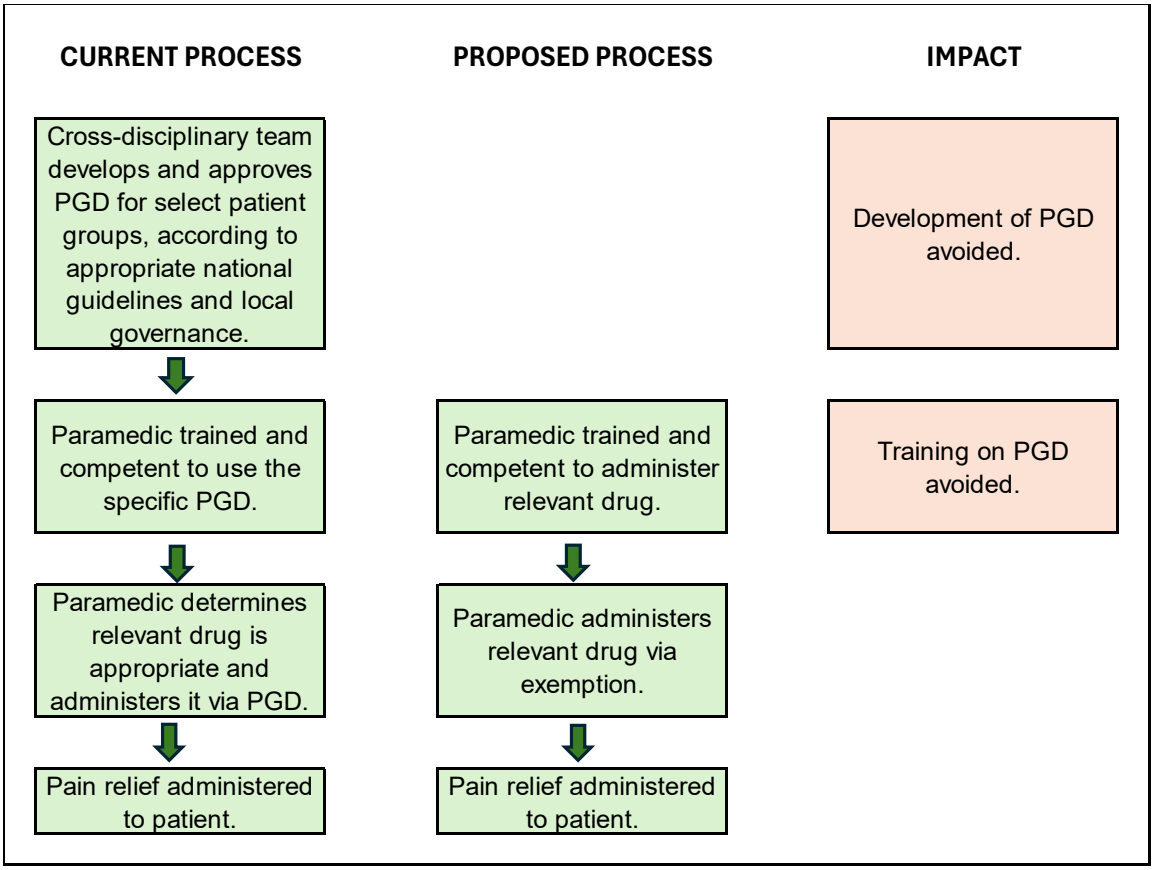
2.3. The reform could generate significant time savings for paramedics and ambulance services, whilst improving patient experience and pain management.

### Typical treatment processes and expected impacts of reform

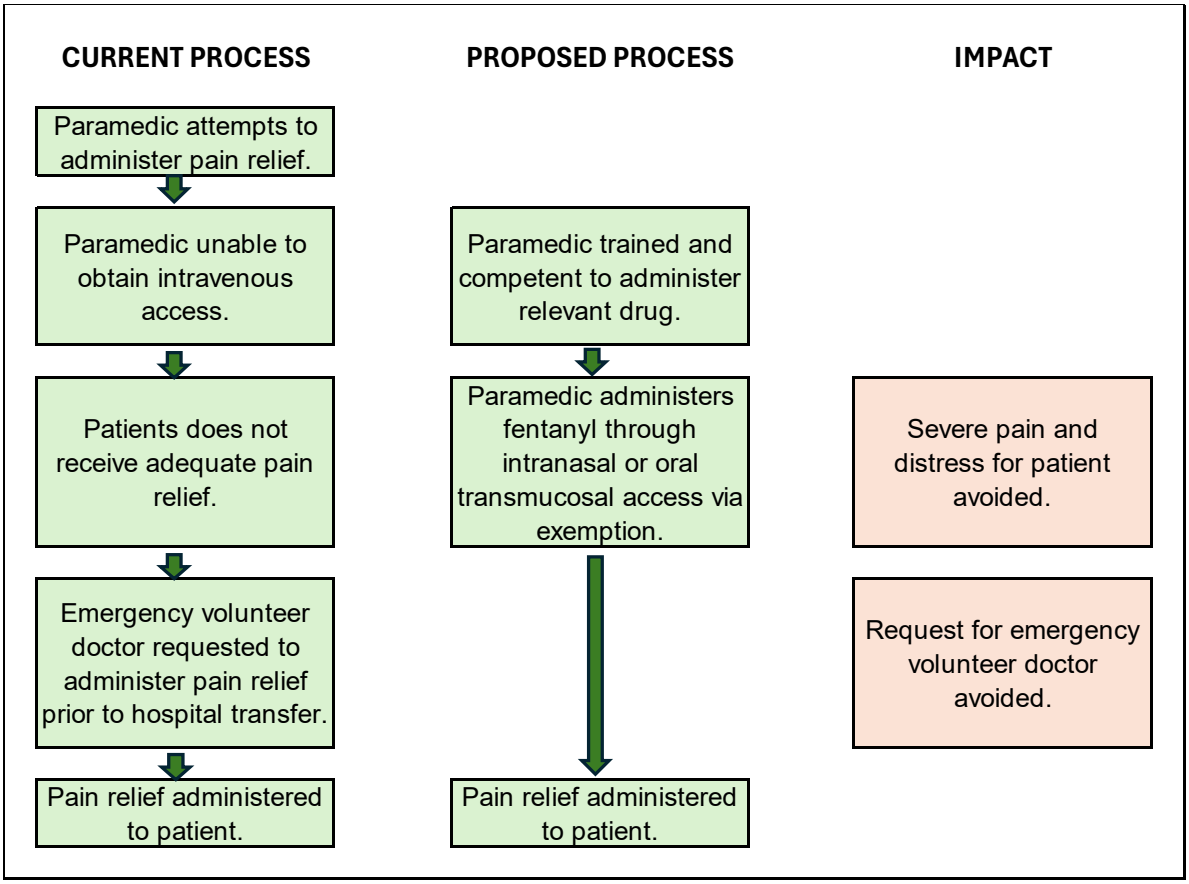
2.4. Every patient is treated as an individual, with appropriate care and medication depending on the circumstances. The additional proposed drugs (except for fentanyl) are currently administered by paramedics via PGD. There is currently no provision for patients to receive any form of fentanyl by paramedics.

2.5. The process can be illustrated diagrammatically as below.

*Administration via PGD*




*Administration of fentanyl*



### Number of clinicians affected

2.6. The potential reform would impact all registered paramedics. However, for this section of the impact assessment we investigate the effects of the reform on NHS paramedics. The impact assessment later discusses the impacts on businesses, which covers the impacts on paramedics working solely in the private or voluntary sector.

2.7. As of April 2025, there are approximately 40,000 paramedics registered with the HCPC. The College of Paramedics estimate that approximately 10% of registered paramedics work exclusively in private settings, and that 90% of registered paramedics work in the NHS (36,000). It is likely that all registered paramedics will benefit and take advantage of the proposed reform.

2.8. The College of Paramedics estimate that around 2,600 paramedics graduate from pre-registration programmes per annum, and that 90% of these new registrants commence their career in employment with an NHS ambulance trust (2,340).

### Assessments of Benefits

2.9. The proposed medicines (not including fentanyl) are already administered on a regular basis via PGD. The College of Paramedics advise that PGD development is estimated to take between 40 and 80 hours, depending on its complexity. A PGD costs approximately £1659[3] to develop and requires sign off from a senior doctor, a senior pharmacist and a governance lead. Each paramedic on a service must be trained and authorised to use each PGD. Once developed, the College of Paramedics estimate that it would take each paramedic between 30 minutes and one hour to read and understand the PGD. Administering the proposed medicines through exemptions removes this costly and time-consuming process. PGDs are typically valid for 3 years.

2.10. Administering appropriate medicines more rapidly under exemptions is likely to improve both immediate patient experience and support better recovery trajectories. The College of Paramedics has advised that specific anticipated health benefits of the proposed reform would include:

- **A reduction in pain and distress**. Fast and effective pain relief without the need for intravenous access through the administration of fentanyl (particularly oral transmucosal and intranasal forms) offers fast and effective pain relief. This is especially beneficial in paediatric patients, those in hypovolemic shock, or where venous access is difficult. Improving pain management could improve patient experience and health outcomes.
- **Improved seizure control**. More timely administration of midazolam may lead to faster cessation of seizures. This reduces the risk of prolonged seizures and associated neurological damage. This is particularly relevant in prehospital care, where early intervention is critical.
- **Reduced maternal and neonatal morbidity/mortality**. The ability to administer magnesium sulfate without delay in cases of eclampsia or severe pre-eclampsia could save maternal and infant lives and reduce Intensive Therapy Unit admissions and complications.
- **Reduced bleeding and better trauma outcomes**. Early administration of tranexamic acid in trauma and head injury cases is linked to improved survival

[3] Please see Annex A.5 for fuller detail on PGD development costs.

and reduced long-term disability, especially when given within 3 hours of injury[4,5]. Timely access via exemptions would support this.

- **Improved outcomes in asthma and arrhythmias**. Quicker access to magnesium for life-threatening asthma and cardiac arrhythmias could prevent deterioration, improve response to treatment, and avoid cardiac arrest or respiratory failure.
- **Psychological benefits.** Faster relief of distressing symptoms such as pain, seizures or breathlessness supports the psychological well-being of both patients and their families in emergency situations.

2.11. Whilst these benefits are not quantitative, it is evident that the proposed reform would generate significant benefits for patients in their journey of care. It is suggested that these benefits will be realised for many patients. The College of Paramedics indicate that in 2024, UK ambulance services treated 378,000 seizures and 350 eclamptic seizures. Additionally, UK ambulance services treat thousands of patients annually for severe pain and trauma. Our provisional analysis suggests that the benefits would largely outweigh the costs. We intend to review this further in the light of consultation.

### Assessment of Costs

2.12. Only the incremental costs associated with administering the proposed controlled drugs and prescription only medicines are relevant to this impact assessment. To comply with registration requirements, paramedics must fulfil their professional obligations to keep up to date with current practice. The proposed medicines (not including fentanyl) are already administered on a regular basis via either PSD or PGD, and so additional training and familiarisation for these medicines is negligible. The largest change of the reform would be the administration of fentanyl under exemptions.

2.13. Although paramedics are used to administering opiates within their clinical practice. The College of Paramedics has designed a training package which will be provided to UK registered paramedics free of charge. The training will consist of a professionally developed, pre-recorded video module, supplemented by a detailed digital handbook and clinical decision-making framework. These will be aligned with current National Institute for Health and Care Excellence (NICE) guidelines, Medicines and Healthcare products Regulatory Agency (MHRA) requirements, and UK-wide controlled drugs governance principles. We are currently unable to quantify the cost of developing this training.

2.14. Training is expected to take approximately one hour per paramedic, based on training carried out by mountain rescue and the military who train non-clinicians in the use of fentanyl. The salary rate used for the paramedics being trained is taken to be the average of NHS bands 6, 7 and 8a, which is £37.17 per hour including oncost adjustments like national insurance.

2.15. The total training cost on these assumptions is around £1.3 million as a one-off impact, plus a further £55,000 per year.

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[4] *Effects of tranexamic acid on death, vascular occlusive events, and blood transfusion in trauma patients with significant haemorrhage (CRASH-2): a randomised, placebo-controlled trial.* The Lancet, Volume 376, Issue 9734, 23 – 32 accessed May 2025 Effects of tranexamic acid on death, vascular occlusive events, and blood transfusion in trauma patients with significant haemorrhage (CRASH-2): a randomised, placebo-controlled trial - The Lancet

[5] Cap, Andrew P. *CRASH-3: a win for patients with traumatic brain injury.* The Lancet, Volume 394, Issue 10210, 1687 – 1688 accessed May 2025 Effects of tranexamic acid on death, disability, vascular occlusive events and other morbidities in patients with acute traumatic brain injury (CRASH-3): a randomised, placebo-controlled trial - The Lancet

**Compliance risks**

2.16. There is a potential risk of non-compliance e.g. inadvertent use of controlled drugs by unqualified staff. The clinical effects of this are likely to be minimal, given that paramedics are currently authorised to possess and administer benzodiazepines and strong opioids. Paramedics are also trained to manage any potential adverse effects of these agents such as decreased respiratory rate, decreased blood pressure or, in extreme cases, loss of airway. Paramedics would also carry the reversal agent for both medicines and have the required training to do so. But there could be adverse consequences. Mitigating the risk would primarily be through the training itself, combined with local systems tracking uptake.

## DETAILED ANALYSIS FOR PHYSIOTHERAPISTS

3.1. The proposal is to allow physiotherapist independent prescribers to prescribe four additional controlled drugs beyond the seven already permitted.[6] These four are:

- codeine phosphate (oral administration)
- tramadol hydrochloride (oral administration)
- pregabalin (oral administration)
- gabapentin (oral administration)

3.2. Tramadol, pregabalin and gabapentin have all been prescribable by physiotherapist independent prescribers in the past, before being reclassified as controlled drugs, and the evidence suggests these restrictions, together with those on codeine, are no longer optimal.

3.3. All four are used for pain relief in the context of physiotherapy[7]. In each case, current prescribing guidance no longer reflects best practice and leads to additional appointments being required, with an increased risk of delay before appropriate treatment can be provided.

### Typical treatment processes and expected impacts of reform

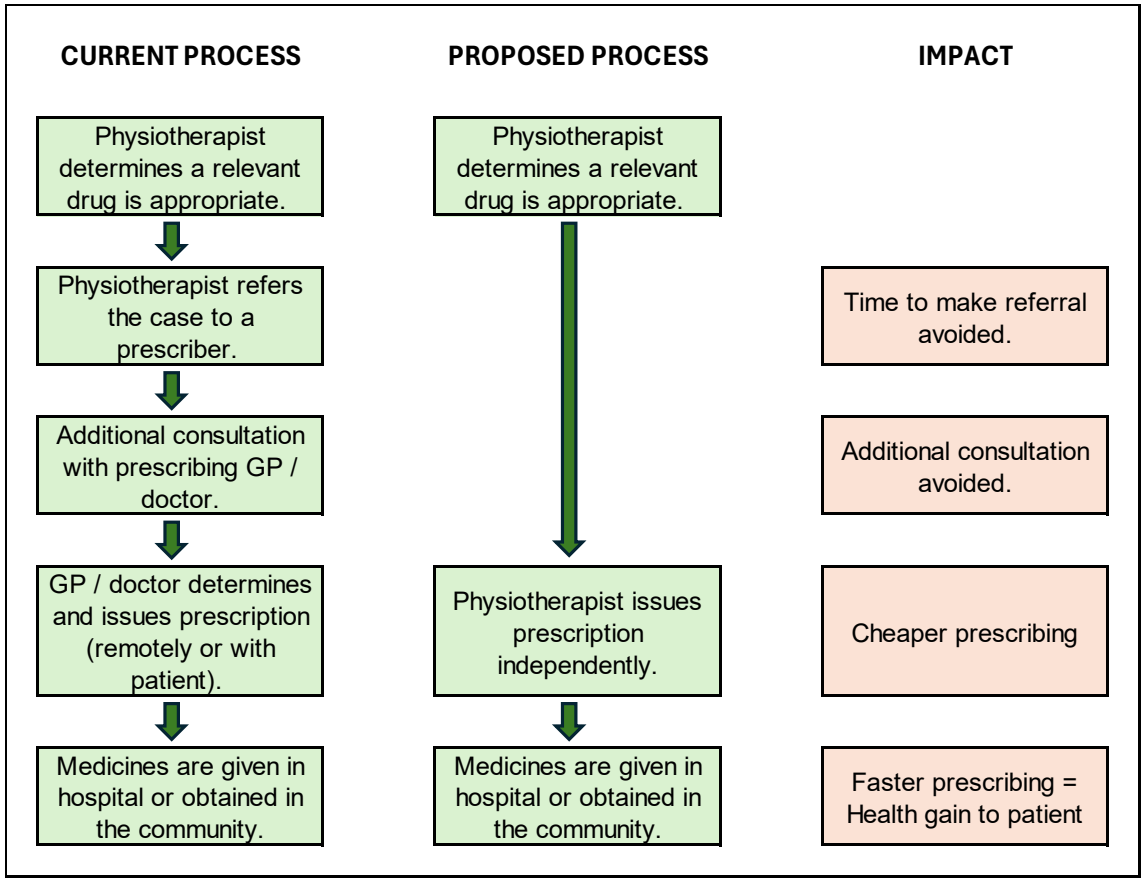
3.4. Every patient is treated as an individual, with appropriate care and medication depending on the circumstances. However, the process for all four controlled drugs is similar in that, if the physiotherapist determines that one of the four drugs is appropriate, they cannot prescribe it independently and must refer to a GP or doctor to issue the prescription.

3.5. The proposed reform will only make a difference if the physiotherapist is qualified to prescribe independently. If they are not a qualified prescriber, then the current process would continue.[8] If they are qualified, or became so, then the referral and any associated delays or costs could be avoided.

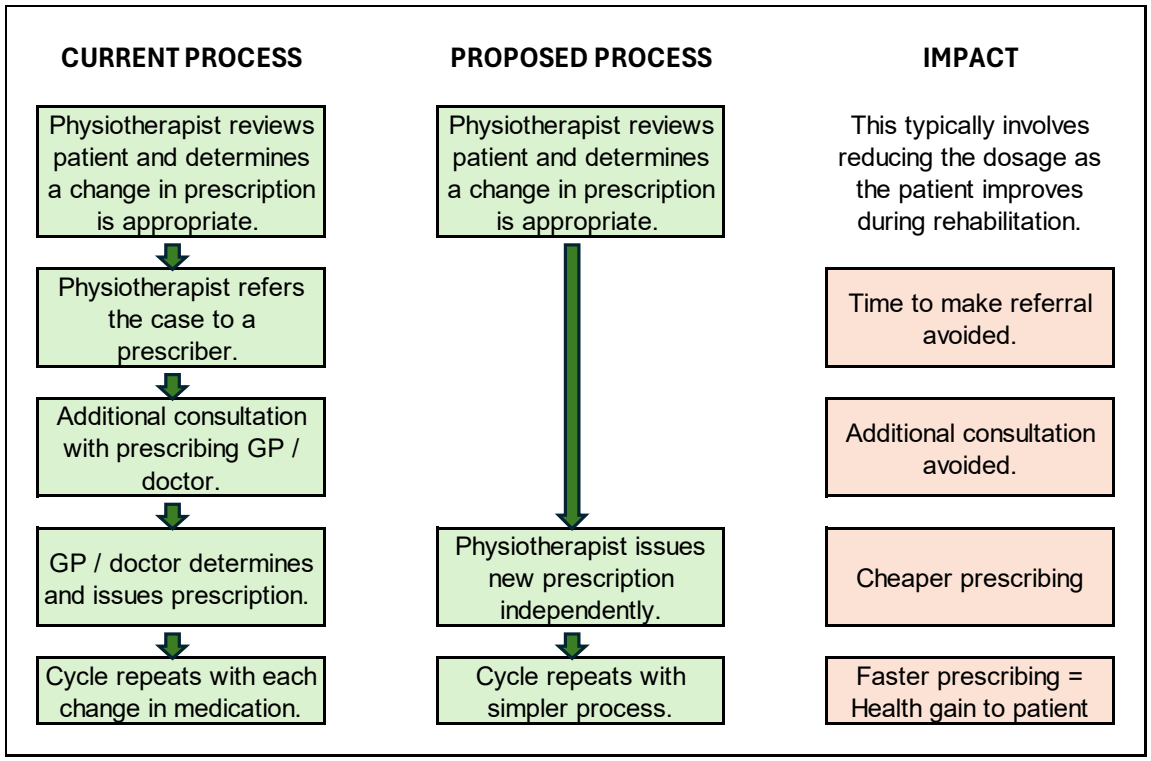
3.6. The process can be illustrated diagrammatically as below.

[6] Physiotherapists who have undergone additional HCPC training have been able to practise as independent prescribers since 2013. They have been able to prescribe from a restricted list of seven controlled drugs since 2015 (Great Britain) and 2019 (Northern Ireland). Those drugs are temazepam (schedule 3, oral administration), lorazepam (schedule 4 part 1, oral), diazepam (schedule 4 part 1, oral), dihydrocodeine tartrate (schedule 5, oral), morphine sulfate (schedule 2 & 5, injectable and oral), fentanyl (schedule 2, transdermal) and oxycodone hydrochloride (schedule 2, oral).
[7] Other uses, not relevant to physiotherapy, may exist. For example, pregabalin and gabapentin are used to treat epilepsy.
[8] There might be an extra option available of referring to a more senior physiotherapist to issue the prescription in this situation, which would offer additional flexibility compared with the current rules.

*Initial patient assessment*




*Subsequent patient review*



**Situations where the reform is expected to make a difference**

3.7. The overall impact will depend on how often the reform makes a difference to the way a patient is managed, and how big that difference is. The Chartered Society of Physiotherapy (CSP) have provided a summary assessment showing where the reform is likely to have the greatest impact. The table focuses on beneficial impacts (any costs are considered later).

| Theme | Where It Makes the Most Difference | Size of Benefit | Frequency |
|---|---|---|---|
| **Patient Safety & Timely Access** | - Primary care<br>- Community rehabilitation<br>- Post-operative care<br>- Chronic pain services | *High impact*—patients avoid delays waiting for GPs or consultants to prescribe; deprescribing from stronger opioids | *Daily*—especially in primary care, community rehab, and long-term condition management teams |
| **Workforce Efficiency & NHS Long Term Plan Alignment** | - Areas with GP shortages<br>- Allied health professions-led services<br>- MSK[9] hubs | *Moderate to high impact*—frees up GP time; reduces prescribing delays | *Ongoing*—key to ICS[10] ambitions and advanced practice expansion |
| **Cost & System Efficiency** | - Primary care<br>- Intermediate care units<br>- Community services | *Moderate to high impact*—fewer repeat appointments; less service duplication | *Widespread*—scales as more physiotherapists become prescribers and take leadership in care pathways |

3.8. In terms of the four controlled drugs, codeine is likely to be used the most often.

**Expected frequency of controlled drug use**

| Drug | Likelihood of Use by Physio prescribers | Common Settings | Clinical Situations |
|---|---|---|---|
| *Codeine* | Very High | FCP[11], MSK, ortho rehab | Acute MSK pain, post-op pain, including deprescribing from stronger opioids |

[9] Musculoskeletal.

[10] Integrated Care Systems.

[11] First Contact Practitioner.

| | | | |
|---|---|---|---|
| *Tramadol* | Moderate | MSK rehab, post-op | Short-term moderate-to-severe MSK pain, including deprescribing |
| *Gabapentin* | High | Chronic pain, neuro-MSK | Neuropathic pain, radiculopathy, including deprescribing |
| *Pregabalin* | High | Chronic pain, FCP (spinal) | Sciatica with nerve root, persistent neuropathic pain, including deprescribing |

3.9. It is not possible to itemise every conceivable situation and type of patient. Instead, we have considered a small number of illustrative case study scenarios, developed with CSP. These are designed to highlight some common scenarios affected by the reform and provide an initial illustrative basis for estimating the likely scale of impact.

3.10. The current consultation and associated analysis should help enhance these illustrations, and it may be possible to provide fuller case studies and additional quantification, should the proposals progress.

3.11. It's important to stress that the case studies do not represent all patients. A referral might not always entail an additional appointment and equally, the physiotherapist might identify a suitable alternative medicine that they could prescribe without referral. On the other hand, impacts could repeat for a single patient during subsequent follow-up monitoring, should changes to their prescription be required.

3.12. The aim is to use the case studies to estimate impacts for a significant proportion of patients, such that the likely overall impact of reform can be judged.

**Overview of case studies**

3.13. The three case studies considered are:

| | **Situation** | **Potential types of case affected** | **Impact of reform** |
|---|---|---|---|
| 1 | First Contact Practitioner (FCP) roles in primary care.<br><br>Appointment with physiotherapist independent prescriber FCP. | Musculoskeletal pain.<br><br>Short-term opioid prescribing (such as codeine).<br>Deprescribing of gapapentioids. | Faster patient care (delays avoided).<br><br>Reduced duration/severity of pain (and consequential benefits arising from that).<br><br>Reduced pressure on staff time in both primary and secondary care (referral avoided).<br><br>Optimal medicines prescribing, including deprescribing form stronger medicines to less potent ones. |
| 2 | Chronic pain services<br><br>Series of appointments / | Rehabilitation from chronic pain – multiple types (neck, back, nerve etc.). | Faster patient care (delays avoided).<br>Cumulative benefit given repeated nature of patient contact. |

| | | | |
|---|---|---|---|
| | referrals with physiotherapist independent prescriber to manage patient. | Typically involves deprescribing (i.e. dose reduction and/or switching to a less potent medicine) but may also involve prescribing.<br><br>Could involve any of the four medicines required. | Reduced duration/severity of pain (and consequential benefits arising from that).<br>Optimal medicines prescribing, including deprescribing form stronger medicines to less potent ones.<br>Reduced pressure on staff time in both primary and secondary care (repeated referrals avoided). |
| 3 | Rehabilitation following knee-replacement surgery.<br><br>Physiotherapist independent prescriber.<br>Ward discharge services.<br>Acute hospitals. | Post-operative recovery (e.g. hip or knee replacement, acute injury etc.).<br><br>Tramadol required. Situations where discharge is delayed under current rules. | Promotes continuous therapy with no risk of delay and temporary pauses in medication.<br>Faster patient recovery.<br>Faster discharge.<br>Cumulative benefit if repeated patient contact involving changes in medication (also facilitates changes to simpler painkillers as recovery progresses).<br>Improved patient experience (less pain, less need to see a range of clinicians). |

3.14. All three case studies are high impact (in terms of the difference the reform might make for an individual patient case). The first is high volume, the second moderate volume – both relatively common scenarios. The third is less common (but also a more specific situation).

3.15. Each case study is detailed in full in the annex. In essence, they are variants of situations where a physiotherapist independent prescriber identifies that a controlled drug is appropriate but is unable currently to prescribe it. This then requires referral to a prescribing GP or other doctor to prescribe the medicine. The proposed reform would remove this referral requirement.

**Assessment of benefits**

3.16. Limited quantification is possible for each case study at this stage.

- we estimate the number of cases where the reform might make a difference;
- we estimate the value per referral avoided in terms of NHS time and cost;
- we estimate the number of clinicians affected and associated training costs;
- all other impacts, including patient and health effects, opportunity benefits, and any indirect effects, are described but not monetised.

3.17. Overall, these three case studies have estimated benefits as follows:

*Reduced need for referrals*

3.18. This is the primary benefit, from which most other benefits flow.

3.19. Allowing a physiotherapist independent prescriber to prescribe an additional four controlled drugs on their own saves both their time in making the referral, and that of a second prescriber in reviewing the patient and issuing a prescription.

3.20. Referrals may involve an extra patient appointment (either in person or by phone), or they might involve a remote review of the patient case notes only. The time taken is very variable and dependent on the patient, setting, familiarity of the prescriber with the patient, whether files are electronic or paper-based, and other factors. Precise estimates are not available, but our analysis includes a tentative assumption that 70% of cases might involve an extra patient appointment, and 30% would not.

3.21. Indicative volumes and associated NHS savings are as follows (with the detailed analysis explained in the annexed case studies).

| Case study | Volume per year | Monetised NHS savings (£m per year)[12] |
|---|---|---|
| 1 (first contact in primary care – codeine) | 1.15 million | 42.5 |
| 2 (chronic pain services – gabapentin/pregabalin) | 500k | 18.5 |
| 3 (ward discharge services – tramadol) | 14k | 0.5 |
| Total | 1.65 million | 61.5 |

3.22. These estimates are indicative. The volume, in principle, includes only cases where the reform would make a difference, and then the analysis assumes that benefits would accrue in every such case. Confidence in the delivery of benefits in affected cases is high, while the actual volumes are less certain. Uptake by physiotherapists and achieving full coverage would take time. The benefits are thus longer-term projections.

3.23. The case studies are examples only – they do not cover all situations likely to be affected by the reform.

3.24. For additional perspective, CSP have noted that around 20 million patients have MSK problems being treated through primary care, many of them seeing physiotherapists. They further suggest that 20% or 4 million might require codeine. This could imply a long-term potential of up to 4 million potential beneficiaries of the reform, for that one medicine alone. However, more work is needed to firm up these figures and gauge the most plausible level of impact.

[12] In practice, savings are unlikely to be seen as financial savings but instead they represent freed-up clinician time to treat other patients.

*More efficient prescribing*

3.25. The reform is expected to reduce pressure on clinicians in both primary and secondary care, depending on the type of patient.

3.26. A typical referral to a GP involves 10 minutes of GP time. If 1.5 million referrals were avoided, that frees up 1.5 million appointment slots. In practice, cases involving patient contact will free up more time than those involving a remote review of patient notes.

3.27. If referrals were instead made to doctors in secondary care, then the same principle applies.

3.28. The physiotherapist currently making a referral would also save some administrative time, but they would now need to issue the prescription. An increase in net time of around 6 minutes within the FCP appointment is expected.

3.29. Salary costs are such that it is cheaper for a physiotherapist independent prescriber to prescribe the relevant drugs than to go through referral to a GP, so this, coupled with the net time saving delivers a significant efficiency gain.

3.30. These benefits are enhanced where, as is current policy, rehabilitation activity is more community or home-based than in hospital (such that staff may be spread more thinly, and referral times and delays may be longer).

*Improved patient care*

3.31. It is difficult to quantify impacts on a per patient basis, since every case is different. In qualitative terms, several types of benefit are possible as follows.

- Reduced delays in assessment, prescribing and administration of medicine;
- Improved patient experience, resulting from faster treatment or symptom relief, and also from fewer touchpoints being needed to receive their care;
- Improved patient safety, through reduced polypharmacy risks and errors, better clinical integration and better continuity of care;
- More equitable treatment, resulting from less variation in treatment onset;
- Improved health outcomes, including faster/better recovery, again resulting from the above factors.

*Consequential benefits*

3.32. Indirect effects arising from faster treatment, such as reduced sickness absence. Many people are economically inactive due to chronic pain conditions and physiotherapy has a growing role in the interface between work and health. There is greater emphasis on keeping people in, or returning them to, work through health interventions.[13] As such, enabling physiotherapists to fully manage pain and function aligns with DWP and DHSC goals to reduce long-term sickness and support people into employment.

[13] DWP & DHSC (2023). "Health and Disability White Paper"; also, the "Fit note reform consultation 2023". WorkWell Pilots

3.33. Opportunity benefits if clinician time is freed up and becomes available to care for other patients (although this should not be double counted with the NHS savings since they represent the same thing). The reform offers the potential to reduce waiting lists, particularly where demand for MSK services is high. MSK conditions account for over 30% of GP appointments (NHS England, 2024).

3.34. The Long-Term Workforce Plan (2023) highlights the shift towards integrated, community-based care, with rehab seen as essential to tackling waiting lists, together with an increasing number of physiotherapists moving into advanced clinical practitioner roles across different specialties to address workforce issues.

3.35. Many of these benefits are not quantifiable but are logically expected to follow from the reform.

**Assessment of costs**

3.36. The main costs associated with the proposed reform are expected to include:

- a potential loss of any indirect benefit arising from referral to a second clinician (e.g. if the referral identified an issue or treatment that a physiotherapist independent prescriber could not identify on their own).

*Training costs for existing independent prescribers*

3.37. The proposed reform will allow physiotherapist independent prescribers to prescribe four additional controlled drugs. They are already expected to be familiar with those drugs, and all HCPC-regulated independent prescribers will have received training in the associated pharmacology, prescribing governance and decision-making for those additional drugs. Clear national guidance on the drugs themselves already exists (through NICE, CSP and NHS England) and would continue to be followed.

3.38. Physiotherapists would require a small amount of additional time to familiarise themselves with the new rules, but this is expected to be of minimal duration and impact, given the extensive knowledge already held.

3.39. Other medical staff (for example pharmacists, referral clinicians and other prescribers) might also need to become familiar with any rule changes, but again the time involved is expected to be minimal.

3.40. The minimal and incremental nature of the training (most of the necessary knowledge is already held) means that any opportunity cost of staff being taken away from front-line duties to be trained, is also expected to be minimal.

*The number of physiotherapists qualifying to prescribe independently could increase*

3.41. The proposed reform does not require any change in the number of independent prescribers, but it is nonetheless expected to encourage more physiotherapists to seek independent prescribing status. This is because the qualification would become more

useful and relevant, especially for those working in pain management, orthopaedics/musculoskeletal care and community rehabilitation – all areas where the four additional controlled drugs are commonly used.

3.42. It is difficult to isolate the precise effect of the reform from other factors that might influence the numbers of physiotherapists joining the profession and developing within it. CSP have provided indicative figures as follows, based on there currently being around 2,684 physiotherapist independent prescribers.

**Assumptions on Impact on Prescriber Numbers**

| Stage | Estimated Change |
|---|---|
| **Short-term (first 12–18 months)** | 20–30% increase in new prescribers (approx. +500-800 physiotherapists) |
| **Medium-term (3–5 years)** | Doubling of current prescribers, reaching **5,300** physiotherapists |
| **Long-term (5–10 years)** | Prescribing becomes standard for all advanced practice roles; **10–15% of the UK physio workforce** (~7,000–10,000) could hold IP annotation |

3.43. CSP support these estimates by noting links with the NHS long-term workforce plan and service models (which encourage upskilling of prescribing to relieve pressure on GPs and secondary care and this improve productivity) and an expansion of university prescribing course provision (because of rising demand).

3.44. If this reform did lead directly to the number of physiotherapist independent prescribers trebling then that would generate substantial additional capacity and benefit, but also more significant training costs.

3.45. We intend to review the evidence following consultation to better understand the impact of this reform specifically, as distinct from other factors. For the time being, we simply note that the impact of reform on the size of the independent prescribing workforce may be very significant. Any estimates of savings might need to be adjusted (probably upwards) in the light of this review.

*Compliance risks*

3.46. Although unlikely, there is a potential risk of non-compliance e.g. inadvertent use of controlled drugs by unqualified staff. The clinical effects of this are likely to be low, given that independent prescribers will be familiar with the drugs being used even if they have not received all supplementary training. But there could be adverse consequences. Mitigating the risk would primarily be through the training itself, combined with local systems tracking uptake.

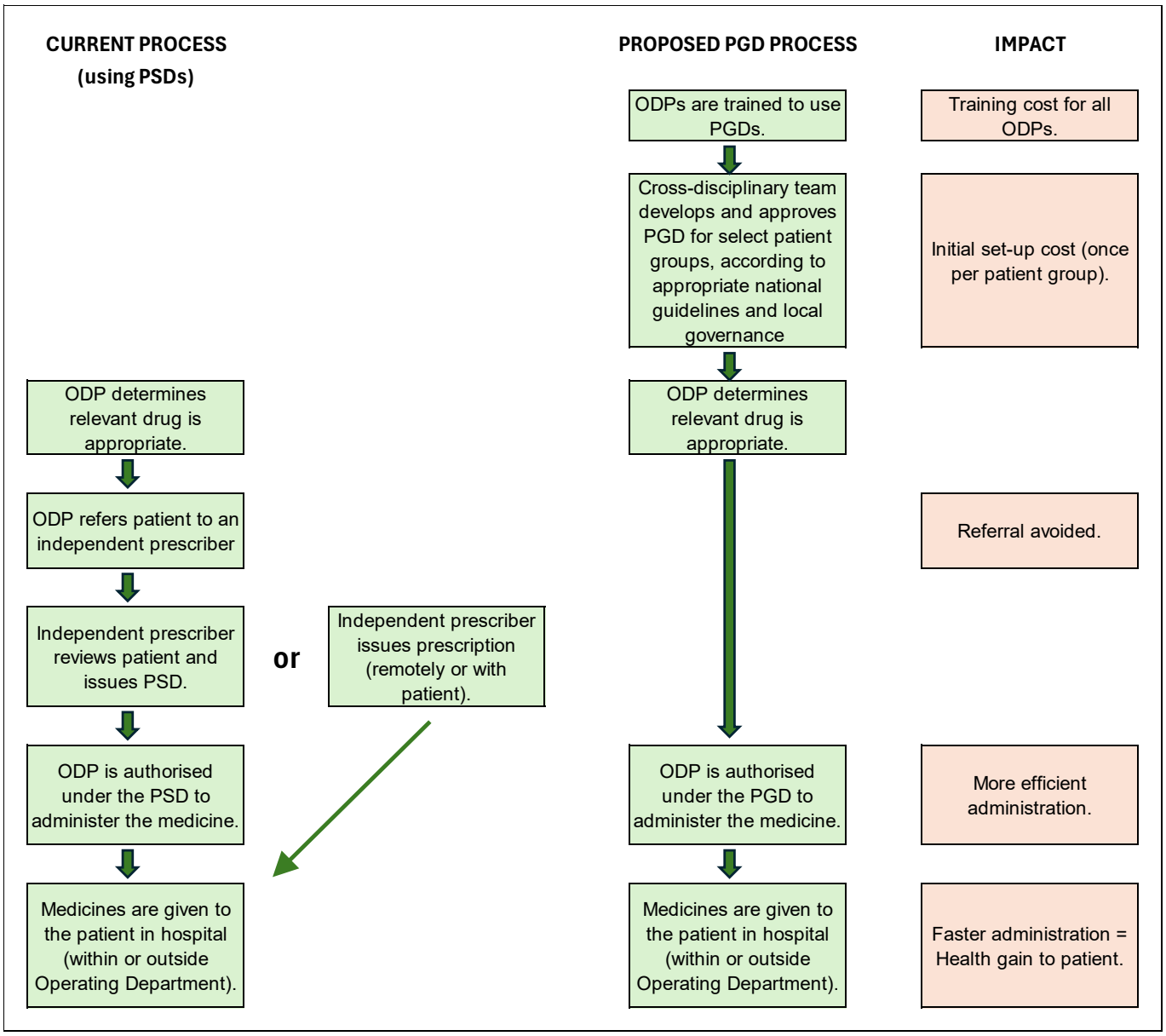
## DETAILED ANALYSIS FOR OPERATING DEPARTMENT PRACTITIONERS

4.1. The proposal is to allow all HCPC-registered ODPs to supply and administer medicines using PGDs.

4.2. This would enhance the current system which allows ODPs to use PSDs only. PSDs require direct input from an independent prescriber to set up for each patient before use.

### Typical treatment processes and expected impacts of reform

4.3. In situations where the type of patient can be defined in advance, and thus be suitable for the PGD approach, the process would change as follows:



**Situations where the reform is expected to make a difference**

4.4. The proposed reform will only make a difference if (1) the patient is in a pre-defined group where a PGD is permitted to be used, and (2) if the ODP is suitably trained. In other situations, the current process would continue.[14]

4.5. It is not possible to itemise every conceivable situation and type of patient. Instead, we have considered a small number of illustrative scenarios, developed with the College of Operating Department Practitioners (CODP). These are designed to highlight some common scenarios affected by the reform and provide an initial illustrative basis for estimating the likely scale of impact.

4.6. It is not possible at this stage to quantify the number of cases where reform might make a difference, and as such, the case studies are qualitative and descriptive in nature. The current consultation and associated analysis should help enhance these illustrations, and it may be possible to provide fuller case studies and additional quantification, should the proposals progress.

4.7. It's important to stress that the case studies do not represent all patients. The time currently taken to refer to an independent prescriber may be very variable and may or may not lead to significant delay. Such referral might be a one-off or might repeat for a single patient during subsequent follow-up monitoring, should changes to their prescription be required.

4.8. The aim is to use the case studies to estimate impacts for a significant proportion of patients, such that the likely overall impact of reform can be judged.

**Overview of case studies**

| | **Situation** | **Potential types of case affected** | **Impact of reform** |
|---|---|---|---|
| 1 | Senior ODP / Resuscitation Practitioner Anaesthetics & Recovery Independent hospital | Anaesthetics, pain management, recovery, *r*esuscitation. | Faster patient care (delays avoided). Reduced pressure on staff time (referral avoided). |
| 2 | ODP in an Eye Infirmary. Hospital setting. | Administration of eye drops for day cases. | Faster and more efficient process. Easier list management. Better patient experience. Reduced delays. |

[14] There might be an extra option available whereby an untrained ODP could refer to a trained ODP, which would offer additional flexibility compared with the current rules.

| | | | |
|---|---|---|---|
| 3 | Streaming & triage clinician.<br>Interface between Emergency Department and Urgent Treatment Centre.<br>Secondary care. | Analgesics, antihistamines, cases with breathing difficulties. | Reduced delays.<br>Improved patient experience and health (especially if in distress e.g. breathing problems or children).<br>Reduced pressure on clinicians (referrals avoided). |
| 4 | Ward manager.<br>Acute Psychiatric Hospital.<br>*(or, similarly)*<br>Unit manager.<br>Emergency Care Unit. | Wide range of situations – pain relief, antibiotics, life-saving medications such as adrenaline. | Faster patient care (delays avoided).<br>Delayed discharge avoided.<br>Reduced pressure on staff time (referral avoided). |
| 5 | Critical care outreach practitioner.<br>Intensive care medicine.<br>Hospital setting. | Hypotensive septic shock.<br>Cardiac arrest.<br>IV fluid management. | Reduced delays (referrals avoided).<br>Reduced limitations on what can be administered quickly.<br>Better patient outcomes. |
| 6 | Resus trauma practitioner.<br>Major trauma centre. | Trauma patients.<br>Massive haemorrhage cases on wards.<br>Paediatric cardiac arrests.<br>Medical assistance calls. | Reduced delays (referrals avoided).<br>Improved patient experience and comfort (e.g. faster symptom relief, more effective local anaesthetic).<br>Less pressure on referral staff. |

4.9. The reform is expected to make the biggest difference within operating departments in Ophthalmic Lists where for each operating list, a range of eye drops are administered prior to the surgical procedure. Also, the administration of anti-emetic medications in post anaesthetic care units.

4.10. Outside of operating departments, typically the reform would make most difference in areas such as emergency departments, endoscopy departments and resuscitation teams.

4.11. All the case studies share similar characteristics in that the use of PGDs by ODPs is expected to reduce delays in treatment, reduce pressure on staff and improve patient wellbeing and health outcomes. This is true across a wide variety of settings, patient conditions, and therapies. Any costs associated with the reform (such as training) are also likely to apply in a fairly similar way across these varied scenarios.

4.12. The case studies are presented with additional detail (e.g. with reference to particular medicines that might be prescribed) in the Annex.

**Assessment of benefits**

4.13. At this stage, the analysis is qualitative and by extension unmonetised.

4.14. The main benefits of reform are expected to include:

*More efficient administration*

- fewer referrals being required, because the availability of PGDs would remove the need to refer to obtain a PSD;
- saving of clinician time in making that referral;
- removal of independent prescriber time spent reviewing the patient and issuing a PSD (or possibly the prescription itself);
- reduced pressure on independent prescribers in secondary care (by extension from the previous bullet);
- easier list management within secondary care.

*Improved patient care*

- reduced delays in assessment, prescribing and administration of medicine;
- improved patient experience, resulting from faster treatment or symptom relief;
- more equitable treatment, resulting from less variation in treatment onset;
- faster patient discharge from operating departments to a ward, or to home;
- improved patient safety, resulting from faster treatment;
- Improved health outcomes, again resulting from the above factors.

*Consequential benefits*

- indirect effects arising from faster treatment, such as reduced sickness absence.

**Assessment of costs**

4.15. At this stage, the analysis is largely qualitative and by extension unmonetised. Some staffing figures are available for perspective, but they are limited.

4.16. The main costs associated with the proposed reform are expected to include:

*Training ODPs to use PGDs*

4.17. NICE strongly advises that ODPs should receive specific training before using PGDs (as is currently encouraged for all health professionals using this mechanism), and publishes a competency framework setting out the skills and knowledge expected by those who undertake the writing, reviewing, implementation and use of PGDs. ODPs would be professionally accountable for their decisions, including actions and omissions and must ensure they provide evidence-based care within their scope of practice and competence.

4.18. Training could be provided through the Specialist Pharmacy Service or locally through employers (NHS Trusts) in pharmacy departments.

4.19. The cost of setting up and delivering training and support for ODPs to use PGDs is a one-off cost in development terms, and a one-off cost per clinician. There might be some ongoing costs as either new clinicians start training, or the training itself is reviewed and improved over time.

4.20. Any opportunity cost if such training takes ODPs away from their front-line role should also be considered. This would be a one-off upfront cost that would be offset in time as the need to spend time on referring patients fell. Training duration is uncertain but could potentially last around half a day.

4.21. Some additional training might be required for using PGDs with controlled drugs in particular (where such drugs are included within particular PGDs).

4.22. The precise number of ODPs who would receive the additional training is unclear but is expected to be a majority. There are currently nearly 17,000 ODPs registered with HCPC[15]. Training would likely be staggered over time. CODP estimates that around 600 new recruits would require training annually, once training for existing staff had been completed. Staff are typically NHS band 5 or band 6.

4.23. Training costs are unmonetised at this stage, as hours of training per clinician and the cost of the training course itself is presently unknown.

*The development of PGDs themselves*

4.24. The cost of setting up the PGDs themselves for any suitable patient group would occur every 3 years under current rules. It would involve a multi-disciplinary team determining which categories of patient could be covered by a PGD, developing the PGD and associate guidance, and ensuring that all national guidelines and local protocols are followed. The cost has not at this stage been quantified explicitly for ODP situations, but a generic estimate of £1,659 is available (see annex 5). This one-off cost can be assumed to be lower than the cumulative cost of reviewing each patient individually, which is what the current PSD approach requires.

*Compliance risks*

4.25. There is a potential risk of non-compliance e.g. inadvertent use of PGDs by untrained staff, or of PGDs being wrongly applied to patients with different circumstances from those expected. Such events, while hopefully rare, would potentially have adverse consequences. Mitigating the risk would primarily be through the training itself, but setting up local protocols, validating procedures and supervising less experienced staff would also represent an extra cost.

*Consequential effects*

[15] Registrant snapshot - 1 April 2025 | The HCPC

4.26. There could be a potential loss of any incidental benefit arising from referral to a second clinician (e.g. if the referral identified an issue or treatment that a ODP could not identify on their own).

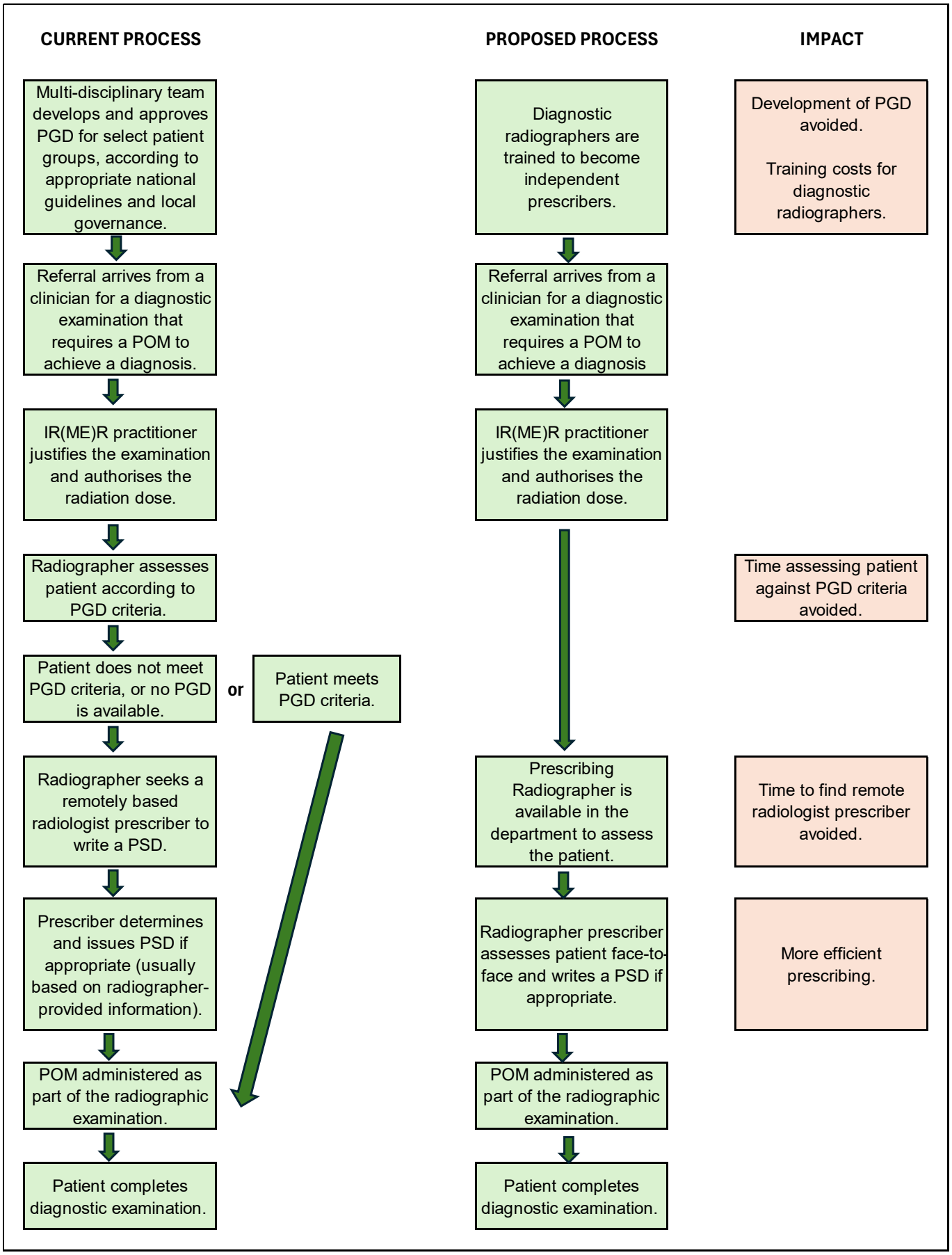
## DETAILED ANALYSIS FOR DIAGNOSTIC RADIOGRAPHERS

5.1. The proposed reform would enable advanced, enhanced and consultant diagnostic radiographers to prescribe medicines independently across the UK, following completion of approved training and a prescribing annotation on the HCPC register.

5.2. The main purpose of diagnostic radiographer independent prescribers is to enable those working at an enhanced, advanced, or consultant level of practice to independently prescribe medicines within the clinical imaging pathway. This ensures patients are seen in a timely and safe manner by well-trained, experienced practitioners and allows them to access the appropriate medicine promptly and without the need for the further intervention of other health professionals. This would use the skills of diagnostic radiographers to their full potential.

### Typical treatment processes and expected impacts of reform

5.3. Medicines are currently administered via a prescription supplied by a radiologist prescriber, a referrer or via a PGD developed by a multi-disciplinary team. The process can be illustrated diagrammatically as below.


CURRENT PROCESS
PROPOSED PROCESS
IMPACT
Multi-disciplinary team develops and approves PGD for select patient groups, according to appropriate national guidelines and local governance.
Referral arrives from a clinician for a diagnostic examination that requires a POM to achieve a diagnosis.
IR(ME)R practitioner justifies the examination and authorises the radiation dose.
Radiographer assesses patient according to PGD criteria.
Patient does not meet PGD criteria, or no PGD is available.
or
Patient meets PGD criteria.
Radiographer seeks a remotely based radiologist prescriber to write a PSD.
Prescriber determines and issues PSD if appropriate (usually based on radiographer-provided information).
POM administered as part of the radiographic examination.
Patient completes diagnostic examination.
Diagnostic radiographers are trained to become independent prescribers.
Referral arrives from a clinician for a diagnostic examination that requires a POM to achieve a diagnosis
IR(ME)R practitioner justifies the examination and authorises the radiation dose.
Prescribing Radiographer is available in the department to assess the patient.
Radiographer prescriber assesses patient face-to-face and writes a PSD if appropriate.
POM administered as part of the radiographic examination.
Patient completes diagnostic examination.
Development of PGD avoided.
Training costs for diagnostic radiographers.
Time assessing patient against PGD criteria avoided.
Time to find remote radiologist prescriber avoided.
More efficient prescribing.

## Number of clinicians affected

5.4. The HCPC registrant data indicates that as of April 2025, there are 48,400 radiographers in the UK. It is assumed that the split between diagnostic and therapeutic radiographers is 86% and 14% respectively (based on a 2016 DHSC estimate).

5.5. Estimates for the number of advanced, enhanced and consultant diagnostic radiographers are based on assumptions provided by The Society and College of Radiographers (SCoR).

| | |
|---|---|
| Total number of HCPC registered radiographers (April 2025) | 48,400 |
| Of which, assumed to be diagnostic radiographers (86%) | 41,600 |
| Diagnostic radiographers at **advanced or consultant** practice level (20%) | 8,000 |
| Diagnostic radiographers at **enhanced** practitioner level who would require training (25%) | 10,000 |
| Total number of advanced, enhanced and consultant diagnostic radiographers across the NHS and private sector | 18,000 |
| Total number of advanced, enhanced and consultant diagnostic radiographers in the NHS (90%) | 17,000 |
| Estimated number of radiographers to take up training initially | **1,200** |

5.6. The proposed reform would permit around 18,000 diagnostic radiographers to undertake training to become independent prescribers, of which 17,000 are assumed to work within the NHS. Assumptions from SCoR anticipate initial interest from those who are already trained as supplementary prescribers, as well as each clinical department seeking to develop one independent prescriber in CT, MRI, and ultrasound, plus those performing interventional procedures. Given practical constraints, we estimate that the initial training interest in the first year is around 1,200 clinicians.

5.7. Based on assumptions from SCoR, the analysis estimates 4 newly recruited prescribers annually per clinical department after the initial training impact. Assuming 229 NHS trusts, this is an annual churn of approximately 900 diagnostic radiographers.

## Assessment of Benefits

5.8. The NHSE Diagnostic Imaging dataset[16] indicate that demand for all examinations, especially CT and MRI, continues to rise. Demand is expected to continue growing, with most cross-sectional imagining examinations requiring a prescription only medicine.

5.9. The NHSE allied health professions medicines team supported by SCoR previously advised that specific anticipated health benefits of the proposed reform would include:

- **Faster access to treatment.** Fewer delays and reduced need for additional appointments. This streamlines care, saving time for patients and clinicians and improving patient experience.
- **Improved use of workforce skill and capability.** Creates additional capacity in acute and elective imaging services through the development of enhanced, advanced and consultant practice radiographers.
- **A prescriber in community facilities.** This enables a radiographer to act as a prescriber in community facilities where medical prescribers are not available. This could enhance the service delivery, development of the workforce and inform career choices, ultimately supporting recruitment and retention.

5.10. Diagnostic radiographers currently administer prescription only medicines through a PGD or by a PSD provided by a prescriber, usually a radiologist. A PGD costs approximately £1659[17] to develop and requires sign off from a doctor, a pharmacist and sign off by the organisation authorising its use. Each clinician working under the PGD must be trained and individually authorised. PGDs are typically valid for 3 years. Independent prescribing might eventually remove this costly and time-consuming process.

5.11. The SCoR indicate that having access to an on-site prescriber could save radiographers and patients up to 2 hours a day. Based on the average salary for an enhanced practitioner, including oncosts adjustments like national insurance, time saved could generate savings of up to £68.50 per radiographer per day. This is an upper estimate, and actual savings would depend on case load.

**Assessment of Costs**

5.12. In line with other professions, diagnostic radiographers who have a proven need and organisational support to become independent prescribers must complete an approved training course that meets the standards for prescribing set by HCPC. Courses usually take 6 to 12 months to complete, depending on attendance and assessment timing, and cost between £1,200 and £2,800. For this analysis, we assume training on a part-time basis of 8 hours a week, lasting for 12 months. Cost of the course is taken as £2,000.

5.13. SCoR anticipate that the first trainees are likely to be at advanced or consultant practice level. The salary rate used for the initial diagnostic radiographers being trained is taken to be the average of NHS bands 7, 8a, 8b and 8c which is £48 per hour including oncost adjustments like national insurance. The salary rate used for future training is taken to be the average of NHS bands 6 and 7 which is £34.25.

5.14. The initial training cost based on these assumptions is around £26.6 million as a one-off impact (existing staff trained in the first few years), plus a further £14.9 million per year

[16] https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostic-imaging-dataset/

[17] Please see Annex A.5 for calculation of PGD development costs.

(training of subsequent people in later years). Both the timing, and salary rates may vary and are uncertain at this stage.

5.15. Training is likely to be limited by training budgets, the availability of designated prescribing practitioners to provide clinical supervision and the opportunity to release staff.

**Compliance risks**

5.16. There is a potential risk of non-compliance. Mitigating the risk would primarily be through the training itself, combined with local systems tracking uptake. HCPC standards of conduct, performance and ethics requires registrants to take appropriate steps to minimise risks. The diagnostic radiographer practitioner will have obtained education, training and be assessed as competent in prescribing, which will aid in minimising risk. Professional body guidance indicates the quality assurance measures that should be in place, before implementation and supported by audit.

### Summary of benefits

6.1. The main benefits of the reform across all four professions are expected to be improved use of clinicians' skill set, and thus workforce efficiency, and improved patient care. Streamlining care is expected to save time for patients and clinicians through reduced delays in assessment, improving patient experience and health outcomes.

6.2. Additionally, there may be opportunity benefits if clinician time is freed up and becomes available to care for other patients, such as reduced wait times and subsequent health benefits.

6.3. Savings may be seen from paramedics and eventually from diagnostic radiographers no longer needing to develop PGDs for medicines included in the reform.

6.4. Benefits are likely to outweigh the costs or will very likely accrue to outweigh costs after the initial training impact.

### Summary of costs

6.5. Only the incremental costs associated with the proposed reform are relevant to this impact assessment.

6.6. Training costs vary between professions. Training costs for diagnostic radiographers is anticipated to be the highest of the 4 professions as the reform would introduce independent prescribing. Courses are expected to take 6 to 12 months to complete. However, training is likely to be limited by training budgets, access to a designated prescribing practitioner to support clinical practice and the opportunity to release staff.

6.7. Training costs for ODPs is not quantified at this stage but can be assumed to be lower than the cost of reviewing each patient individually, which is what the current PSD approach requires. The cost of developing a PGD is between £1,000 and £4,000 depending on its complexity.

6.8. Both paramedics and physiotherapists would require a small amount of additional time to familiarise themselves with the new rules, but this is expected to be of minimal duration and impact, given the extensive knowledge already held. The minimal and incremental nature of the training means that any opportunity cost of staff being taken away from front-line duties to be trained, is also expected to be minimal.

6.9. Evidence gaps on training costs for each profession will be tested at consultation.

## Direct costs and benefits to business calculations

6.10. The proposed regulations will apply to the four named professions in the UK. The rules will apply regardless of whether they are working in an NHS setting, the private sector or both. In practice, the large majority are likely to be working in the NHS - the professional bodies estimate that less than 5%-10% are likely to be working exclusively in a private setting. It is true that a significant proportion of clinicians may be employed on an NHS contract with a private firm, but in this case efficiency savings are likely to accrue to the NHS rather than the private firm (but see below).

6.11. All impacts are voluntary, in the sense that clinicians are not required to take advantage of the proposed regulations and flexibilities and employers must support the need to implement the change. However, in practice we expect most employers and individual practitioners would do so over time. That means that costs and benefits relating to service provision (as opposed to health outcomes experienced by the patient) are likely

to accrue to private businesses in line with the proportion of total clinicians working in the private sector.

6.12. The main impacts on business are expected to include:

*Benefits*

- Up to 5%-10% of the main time-saving impact resulting from a reduction in referrals, based on the private sector's market share of clinician activity. The precise value of such savings will depend on the ability of a business to monetise efficiency savings as a gain for that business. It could be taken as a simple cost saving but could also be deployed on new income-generating work. It is not known to what extent business would be able to do this.
- There is a possible benefit from efficiency savings achieved by private firms working on NHS contracts – but only if those savings can be monetised for additional profit. This is judged unlikely – it is more likely that such savings would be recycled into additional NHS care with no change to the actual NHS contract being worked.
- A possible indirect benefit from patients being treated more quickly, leading to reduced sickness absence amongst employees. This may vary with differing average recovery times for each profession.

*Costs*

- Any increase in prescribing time for a clinician who avoids a referral would be netted off against the savings accruing from that avoided referral.
- Any training costs and time for clinicians will be borne by their employers. The majority would fall on the NHS, but around 5%-10% might accrue to firms working solely in the private sector. In practice, skills are transferrable between employers so there may be some indirect apportionment.
- There might be some additional compliance costs to business in checking that staff have appropriate training and qualifications, and ensuring all regulations are correctly followed.

6.13. In summary, the vast majority of costs and benefits will fall on the NHS, with only 5%-10% affecting the private sector. Any impacts on business are (1) expected to be positive and beneficial, and (2) voluntarily incurred – although in practice the uptake rate is expected to be high. The net benefit to business is dependent on the private sector's ability to convert time savings into income-generating activity.

6.14. We expect to provide a quantitative assessment of business impacts post-consultation.

6.15. The reforms are not expected to affect barriers to entry, competition or small businesses in any significant way. Although beneficial, the reforms only affect a small number of clinicians and products as a proportion of total business activity.

6.16. The assumption and expectation that there will be no significant change in treatment (instead just a reduction in delays) means that the impact on the supply chain, manufacturers and so on is likely to be negligible.

## Impact on small and micro businesses

6.17. The proposed reforms will extend training and flexibilities regardless of setting or size of employer. It is not appropriate or beneficial to exclude small or micro businesses from the benefits offered. Nor is it appropriate to provide any kind of exemption from training

requirements, safety regulations and so on. All clinicians and all patients should be treated equally.

6.18. It is conceivable that a small business might benefit disproportionately but this could positive (e.g. if it currently takes them longer to arrange a referral, the savings may be greater) or negative (e.g. if organising training is more difficult) and it is not possible to itemise every possible situation.

6.19. Our general assessment is that the average impacts on small business will be of the same type as larger firms, and of the same broad average size on a per-patient basis. There is no reason to treat small businesses differently.

## Risks and assumptions

6.20. Any relaxation of medicines legislation may conflict with the rationale for introducing those restrictions in the first place and lose any associated benefits. However, in this case, we are not aware of any evidence indicating that this is a significant risk.

6.21. The allied health professions possess extensive knowledge of medicines relevant to their areas of practice. This knowledge is thoroughly integrated into pre-registration education and training programmes, ensuring compliance with the standards of proficiency required for HCPC registration. Such skills and knowledge can be more effectively applied to benefit patients and the NHS.

6.22. As such, the proposed reform is about ensuring that practice matches the current skills and capabilities of the clinical workforce, delivering benefits to patients in the process, and less about removing a safeguarding measure that addressed some hypothetical identified risk. The result is that amending the current restrictions in the way proposed (including safeguards around qualifying staff and training) does not create any significant risk to patient care. Instead, it removes risks resulting from sub-optimal deployment of scarce clinical resources.

6.23. The proposals are being developed in discussion with the four professional bodies, the HCPC, and other expert groups, such as, the Commission on Human Medicines (CHM) and the Advisory Council on the Misuse of Drugs (ACMD).

6.24. HCPC is the statutory regulator of the four professional groups whose prescribing rights are being amended. The HCPC's role is to ensure that their registrants continue to meet HCPC standards, to approve prescribing programmes and to annotate their register to indicate where registrants have prescribing rights.

6.25. CHM and ACMD are bodies are made up of doctors and other clinical professionals with relevant expertise and they are helping to scrutinise the clinical appropriateness and safety of the proposals, and/or develop training. This further ensures that any clinical risks are identified and mitigated.

6.26. There is potential for non-compliance or for training to not be effective, leading to inappropriate or inefficient prescribing, which could lead to costs in some form. This is not considered to be a significant factor given the considerable body of relevant training already provided, coupled with the expectation that recognised professional bodies and/or experienced clinicians will provide or oversee any new training. HCPC code of conduct, performance and ethics requires registrants to take appropriate steps to minimise risks. Clinicians will have obtained education, training and be assessed as competent in prescribing, which will aid to minimise risk.

6.27. It is standard practice for DHSC to consider whether a reform will have any impact on medical supplies (medicines, equipment etc). In this case the expectation is that any impact would be minimal. It is conceivable that faster treatment may lead to a longer duration of treatment, implying a higher quantity of medicines consumed. But it is equally plausible to assume faster treatment may lead to a faster resolution, with the opposite effect. The reform could lead to patients being seen more quickly and a reduction in waiting lists. It is not expected to change the medication prescribed in any significant way (affecting only the speed with which it is prescribed). Thus, the same number of medicines may be prescribed but earlier than they otherwise would have been. The analysis assumes a broadly neutral impact on medicine supply overall.

6.28. Most controlled drug prescribing referrals are made solely to deliver that particular prescription. However, there is a potential risk that if the need for referral is removed then any wider benefits associated with that referral might be lost. This might be the case if the referral were made for more than just prescribing reasons and/or it provided an opportunity to address other issues.

6.29. The reform would not inhibit clinicians asking other clinicians for a second opinion or prohibit them from making a referral if they chose. All HCPC registrants are required to identify the limits of their practice and when to seek advice or refer to another professional or service. The analysis focuses on the time saving resulting from the change in practice, not of all possible referrals. Based on discussion with experienced clinicians, the risk of any wider issues not being addressed is very low.

6.30. Finally, there is an implementation risk that the reforms may not take effect as quickly as intended. This would be the case if training were not made available, or if clinicians were unable to take advantage of it, once the rules had changed. The former is judged to be unlikely, but it is possible that work pressures may mean that uptake is more spread out, rather than occurring immediately. Such a situation would not affect the balance of costs and benefits but could mean that both occur a little later than planned.

## Distributional and wider impacts

6.31. These reforms are not specifically targeted towards any particular demographic or income group. They can affect anyone receiving care from the relevant professional clinicians and with the particular medicines that are within scope. The reforms are also universal, such that both NHS and private patients may benefit.

6.32. It is possible that the reforms may have a disproportionate effect on some types of patient indirectly. For example, if a particular condition is common amongst certain populations (e.g. elderly patients may be more likely to need treatment for hip and knee replacements) then those populations can be expected to experience a disproportionate share of the benefits.

6.33. The reform will impact all locations. Those services or locations with a large volume of patients may experience a high volume of affected cases. They also have more flexibility in minimising the impact of current referrals. Locations with low volumes might experience longer delays if staff are spread more thinly. But many permutations are possible and very situation dependent.

6.34. A reduction in delays, which by their nature are variable, may make treatment more consistent between patients in similar situations. That will improve equality of treatment and potentially lead to less variation in clinical outcomes. There is no evidence, however, to suppose that any particular sub-population would be disproportionately affected.

## A summary of the potential trade implications of measure

6.35. There is no evidence that these reforms would have any significant impact on international trade.

6.36. A more efficient and faster prescribing process would free up clinician time and potentially allow more patients to be treated. This could increase demand for medicines, at least in the short term. Conversely, if overall recovery time is shortened that would have the opposite effect.

6.37. If, indirectly, the reforms encouraged more clinicians to seek training to obtain independent prescriber status, or take advantage of the other proposed changes, then that could conceivably affect overall caseload, clinician training programmes and supporting logistics. However, it is not clear what effect, if any, such influences might have on levels of trade, particularly internationally.

6.38. In practice, we are not aware of any evidence suggesting the reforms would make a material difference to trade. The consultation provides an opportunity to review.

## Other impacts

6.39. There is no evidence at this stage of any significant impacts (e.g. environmental, judicial, ethical) beyond those already identified. This will be reviewed as proposals are finalised and any additional evidence emerges.

## Monitoring and Evaluation

6.40. A monitoring and evaluation plan will be designed at a future date, should the proposed reforms proceed after consideration of the consultation and any other emerging evidence.

6.41. At this early stage, we set out some basic principles and features that we would expect to include within a future plan.

6.42. In general, monitoring would be geared towards assessing whether the policy objective has been met. This was to increase patient access to medicines via the professionals best placed to provide them, whilst being an effective way to manage NHS capacity, in particular reducing pressure in primary care.

6.43. The success metrics (introduced previously, reproduced here for convenience) are:

- Reduced pressure on GPs and the NHS, by removing the need to refer prescribing decisions;
- Reduced costs of treatment, in the same way as above;
- Improved health outcomes, by reducing delays and speeding up treatment whilst simultaneously freeing up capacity in the system;
- Improved equality of access to healthcare; and
- Improved patient experience.

6.44. Questions for the evaluation to consider may include the following (this list is not necessarily exhaustive):

- To what extent have the proposed flexibilities been taken up? This would include an assessment of both numbers of clinicians being trained, and of numbers of patients where the new regulatory flexibilities were used.
- What costs have been incurred e.g. in delivering training?
- What issues and risks have emerged, and how have they been / could they be addressed? This might include any barriers or unforeseen implications, safety issues and similar features.
- What effect have the proposals had on efficiency and effectiveness, including on clinician time spent per case, numbers of referrals, amount of time saved, clinical outcomes and similar metrics.
- What monitoring of compliance has taken place and what were the findings?
- How were communications about the change received and are there any learning points to consider?

6.45. Upfront collation of evidence to form a baseline for comparison will be helpful and should comprise an ideally quantified assessment of current time per case, referral incidence and duration, and clinical outcomes. Such a baseline may of necessity be qualitative in places (similar to some of the case studies) but based on feedback and intelligence collected from clinicians.

6.46. It is not clear to what extent information on “avoided referrals” will be recorded. It is likely that the number of prescriptions made by paramedics or radiographers will be identifiable or could be estimated, but not the amount of time that would have been incurred had such prescriptions continued to need a referral. The impact assessment analysis sets a baseline that will help, and this would need to be reviewed in the light of any changes in patterns of clinical need.

6.47. The overall format, or formats, for evaluation are to be decided but may include statistical analysis (implying a need to collate or ensure availability of data), informal or formal feedback mechanisms, further dialogue with clinician and/or patient representatives, and other activity.

6.48. The timing of any post-implementation review is not yet known. It is likely that each profession would be considered separately, and possibly at different times. Both immediate feedback on implementation, and longer-term assessment, will be important.

## ANNEX

## Case studies and further analysis for each profession

### A.1 Paramedics

### A.2 Physiotherapists

### A.3 Operating Department Practitioners

### A.4 Radiographers

## Supplementary analysis

### A.5 PGD development costs

### A.6 Glossary

## Annex A.1

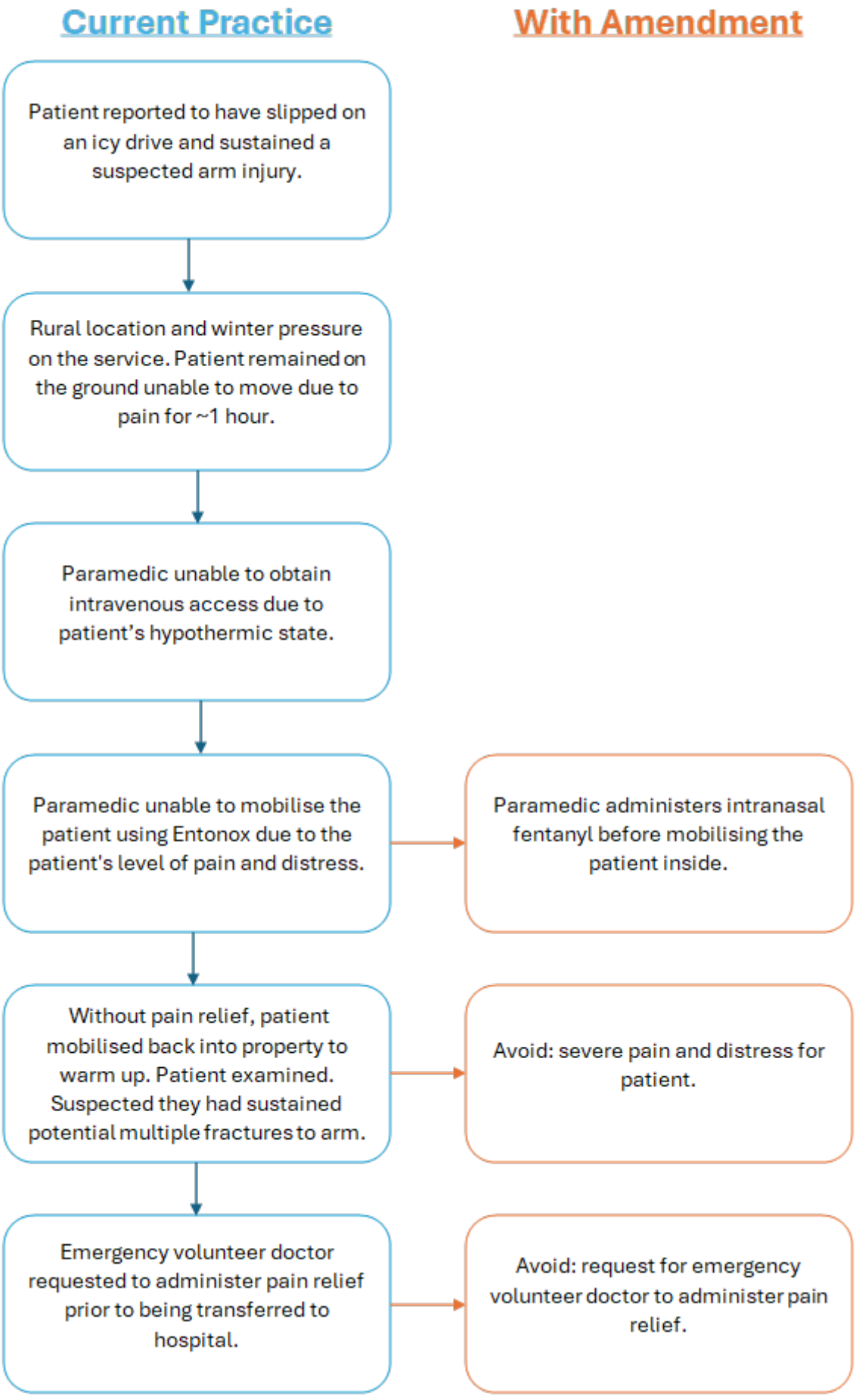
### Illustrative case study for paramedics

This annex provides fuller detail and explanation for a case study of the use of fentanyl relating to paramedics.

Paramedics of all grades (newly qualified paramedics, paramedics and specialist and advanced paramedics) are expected to attend and treat patient in variety of settings including in the prehospital environment and treat severe pain due to either trauma or medical causes.

Currently there is no provision for patients to receive any form of fentanyl by paramedics. This impacts on the ability of paramedics to administer effective pain relief to patients where intra-venous access is difficult (paediatrics or in patients due to physiological or environmental factors, for example patients who are cold, shocked or of a large body habitus). The impact of this longer term is potentially that patients who do not receive adequate pain relief are at increased risk of suffering from post-traumatic stress disorder and chronic pain. Fentanyl has a better profile in terms of faster onset and less side effects compared to morphine.

This case study follows the example of a patient who is experiencing considerable pain due to a fall, and, with the proposed amendment, would have largely benefitted from the administration of intranasal fentanyl.


Current Practice
With Amendment
Patient reported to have slipped on an icy drive and sustained a suspected arm injury.
Rural location and winter pressure on the service. Patient remained on the ground unable to move due to pain for ~1 hour.
Paramedic unable to obtain intravenous access due to patient's hypothermic state.
Paramedic unable to mobilise the patient using Entonox due to the patient's level of pain and distress.
Paramedic administers intranasal fentanyl before mobilising the patient inside.
Without pain relief, patient mobilised back into property to warm up. Patient examined. Suspected they had sustained potential multiple fractures to arm.
Avoid: severe pain and distress for patient.
Emergency volunteer doctor requested to administer pain relief prior to being transferred to hospital.
Avoid: request for emergency volunteer doctor to administer pain relief.

## Annex A.2

## Illustrative case studies for physiotherapists

This annex provides fuller detail and explanation for three case studies relating to physiotherapists.

Common to all three is the expectation that the reform will help avoid unnecessary referrals. By allowing a physiotherapist independent prescriber to prescribe the relevant additional controlled drugs themselves, a GP or other prescriber appointment is avoided, but at the cost of an increase in the time taken by the physiotherapist.

Training and familiarisation costs may also arise.

### Case study 1 First contact physiotherapists (FCP) in primary care (codeine phosphate prescribed)

Codeine phosphate is an opioid used to treat mild to moderate acute and chronic pain. It is considered after non-opioid painkillers such as paracetamol and/or anti-inflammatory medicines have been ineffective or are unsuitable.

Patients who have injuries and/or disease affecting the bones, joints, muscles, soft tissues and nerves (musculoskeletal conditions) can benefit from its effects. Most musculoskeletal conditions do not need surgery or an orthopaedic medical opinion, and physiotherapists help provide early access to treatment and rehabilitation without the need to see a doctor.

Currently, if a patient receiving physiotherapy would benefit from codeine phosphate to support their recovery and rehabilitation programme, the physiotherapist must send the patient to see a doctor, or they must wait until a doctor is available to discuss the case with the physiotherapist. This situation currently occurs frequently and leads to delays in providing effective pain relief and rehabilitation.

This is a high-volume, high-impact prescribing scenario, with large caseloads of patients with musculoskeletal pain where short-term opioid prescribing is relevant.

A typical scenario might involve a patient experiencing back pain, contacting their GP and being given a “first contact” appointment with a physiotherapist independent prescriber. The physiotherapist rules out any need for emergency referral and decides that codeine phosphate would be appropriate for pain relief.

Under current rules, physiotherapists are not allowed to prescribe codeine themselves and must instead refer the patient to a qualified prescriber (GP or doctor). This might often lead to a delay (if no prescriber was immediately available) and potentially a further appointment to see that prescriber. A delay may well worsen and/or lengthen the pain, with consequential implications for the patient’s recovery, ability to work and mental wellbeing.

It might be possible to prescribe an alternative to codeine without delay, but only if such an alternative was covered by existing physiotherapist prescribing rules and was suitable for the patient. In practice, it might be inferior or not suitable at all.

If codeine is added to the authorised list of controlled drugs, then the physiotherapist can independently prescribe this, both at the initial visit and as part of any follow-up monitoring. There is no need for any other clinicians to be involved.

The analysis does assume that the new rules would be applied in every case, and that referrals would not need to be maintained for any reason.

*Potential number of referrals affected*

| | |
|---|---|
| Number of first contact physiotherapists (FCPs)[18] | 2,300 |
| Of which, 70% are independent prescribers | 1,600 |
| Patients seen per week per prescriber | 80 |
| Of which, 25% receive prescription | 20 |
| Of which, 75% are for codeine phosphate | 15 |
| Total number of codeine referrals required per year (48 weeks x 15 per week x 1,600 prescribers) | 1.15 million |

*Impact on a per referral basis*

We assume that an additional 6.5 minutes would be required for the physio to issue the prescription.[19] This is a net increase that takes account of any time saved in no longer making a referral. A GP appointment would typically take 10 minutes, at a higher wage cost. The overall net saving is estimated at £37 per referral as follows:

| | |
|---|---|
| NHS saving<br><br>(i) Physiotherapist avoids need to refer to a GP but now issues prescription. Net increase in time.<br>(6.5 minutes[20], band 7/8a at £68-£77 per hour)<br>Approx £8 cost.[21]<br><br>(ii) Referral GP appointment avoided. | £37 saving[23] |

[18] Oct 2024 estimate of 2,156, uprated to April 2025 in line with general increases in HCPC registrants (about 8% for physiotherapists).

[19] Estimate provided by CSP.

[20] *A comparative case study of prescribing and non-prescribing physiotherapists and podiatrists* (2020) Carey et al. BMC Health Services Research (2020) 20:1074 https://doi.org/10.1186/s12913-020-05918-8

[21] From section 8.2 of The unit costs of health and social care 2024 (for publication) Final.pdf.

[23] This is based on a referral being avoided, but with the saving partially offset by the extra physiotherapist time required to prescribe.

| | |
|---|---|
| (10-minute GP appointment unit cost = £45 including training)<br>Approx £45 saving.[22] | |

A referral including a patient appointment will likely be more time-consuming and costly than one which involves just a paper review. The 10-minute figure is an assumed average - we expect a majority would involve patient contact, but that time taken will vary.

Assuming a £37 monetised net positive benefit each time the proposed prescribing flexibility is allowed, with volume of around 1.15 million per year, the total monetised benefit to the NHS is therefore £42.5 million. In practice, this might be redeployed to other patients with a resultant reduction in waiting times.

There are then several non-monetised benefits on top, related to reduced delays and health gains.

| | |
|---|---|
| Opportunity benefit (appointment slots freed up)<br><br>A separate figure for this is not provided since the £42.5 million saving estimate already measures the NHS benefit and it would be wrong to double-count.<br><br>The benefit could be taken as a straight financial saving, and/or the money could be used to treat additional patients.<br><br>If the latter, then avoiding referrals will improve GP capacity through fewer interruptions being required for medication review. Based on a volume of 1.15 million referrals and an average referral time of 10 minutes, over 190,000 hours could be freed up. | Unmonetised |
| Patient avoids referral appointment.<br><br>The primary benefits for patients are linked to health (see below). But they may also benefit from a time saving if they have to attend fewer appointments or spend less time waiting to be seen.<br><br>The precise time involved will vary considerably with the individual's circumstances, travel time etc. The opportunity cost they put on that time may also vary.<br><br>Purely for illustration, if time were valued at the 2025 National Minimum Wage rate of £12.21, and each | Unmonetised |

[22] From section 9.4.2 of The unit costs of health and social care 2024 (for publication)_Final.pdf

| | |
|---|---|
| avoided referral saved the patient 20 minutes (some combination of travel time, waiting time and contact time) then the valuation would be around £4 per patient, or £4.5m in total. But in practice, this impact is very difficult to quantify robustly. | |
| Health impacts<br><br>In this case study, it is assumed that a referral would be avoided, and hence by implication that a referral would occur under the status quo.<br><br>The delay associated with such a referral might be zero (if a GP were immediately available) or anything from 2 to 7 days (if another appointment needed to be arranged for a different day).<br><br>On the assumption that the patient experienced higher levels of pain during the period of delay, there is thus a QALY health gain for them if the delay is reduced or avoided.<br><br>Also, it is possible in some cases that the delay might lead to a worse health outcome in the longer term. Again there would be a QALY gain.<br><br>This benefit has not been monetised at this time. | Unmonetised |
| Consequent health gain<br><br>Faster treatment, reduced pain, greater equality of treatment and reduced need for appointments may all contribute to better health and faster recovery.<br><br>It is not currently possible to quantify this impact, but it is expected to be significant in many cases. | Unmonetised |
| Effect on patient ability to work (growth agenda)<br><br>Faster recovery and rehabilitation are likely to reduce sickness absence, which can be prolonged for conditions involving physiotherapy. Again, it is not possible to quantify this impact at this stage. | Unmonetised |

**Case study 2 Chronic Pain Services (gabapentin or pregabalin prescribed)**

Gabapentin and pregabalin are non-opioid painkillers.

Gabapentin may be commonly used for treating pain from damage or irritation to the nerve roots in the neck or back which causes pain which is felt in the limbs (radiculopathy). It must be carefully prescribed and monitored with the dose gradually increased and then decreased to ensure safe usage.

Patients who have acute or chronic nerve pain caused by soft tissue injury or chronic spinal disc degeneration, which irritates the nerves in either the arms or legs, may benefit from the use of gabapentin. Many patients will not need surgery, and their condition will settle over a period of months. Some patients will need surgery to remove the cause of the nerve irritation.

Pregabalin may be used to treat pain coming from injury and/or damage to the nerves of the body. This can be central nervous system pain (from the brain and spinal cord) or peripheral nervous system pain (the nerves in the limbs and body) often called radiculopathy. Like, gabapentin, it must be carefully prescribed and monitored with the dose gradually increased and then decreased to ensure safe usage.

Patients who have chronic pain following long-term brain and/or nerve disease such as stroke or multiple sclerosis can benefit from its use. Patients who have acute or chronic nerve pain caused by soft tissue injury or chronic spinal disc degeneration, which irritates the nerves, may also benefit.

Both gabapentin and pregabalin were recently reclassified as controlled drugs. Whilst physiotherapists used to be able to prescribe them, they now cannot do so. If a patient requires a new prescription to manage their condition or requires alterations to their existing prescription to manage their reduction in its use, the physiotherapist must send them to a doctor. This may lead to delays in providing effective pain relief or timely de-prescribing to an alternative lower dose.

This is a moderate-volume, high-impact prescribing scenario, with moderate caseloads of patients typically going through rehabilitation. While initial prescribing is relevant, it is likely that deprescribing (i.e. managing a gradual reduction in dose over time) would be the more common scenario.

A typical pathway for an individual patient might involve a series of appointments and potentially referrals, such that the cumulative impact of that time, and associated delays, could become substantial. For analysis purposes, we focus on the number of appointments likely to be affected.

Similarly to case study 1, if gabapentin and pregabalin are added to the authorised controlled drug list, then the physiotherapist can independently prescribe, throughout the patient pathway. There is no need for any other clinicians to be involved (assuming there are no significant co-morbidities) and ongoing care is likely to be more efficient with fewer clinicians needing to familiarise themselves with each case. Patients would continue to receive access to the appropriate pain relief they require to support their treatment and rehabilitation. Physiotherapists

would be able to provide optimum levels of care in line with good practice guidance, including the timely de-prescribing of a medicine without the delay of waiting for a GP appointment.

*Potential number of referrals affected*

| | |
|---|---|
| Number of physiotherapist independent prescribers (Apr 2025, HCPC database[24]) | 2,905 |
| Of which, 80% work in specialisms which have pain management as the main driver of prescribing | 2,324 |
| Of which, 45% prescribe for chronic pain | 1,045 |
| Patients seen per week per prescriber | 40 |
| Of which, 25% require gabapentin/pregabalin | 10 |
| Total number of gabapentin/pregabalin referrals required per year<br>(48 weeks x 10 per week x 1,045 prescribers) | 500,000 |

*Impact on a per referral basis*

As with case study 1, each avoided referral is estimated to provide an NHS benefit of £37 on a net basis (using the same calculation as previously shown).

With a volume of around 500,000 per year, the total monetised benefit to the NHS is therefore £18.5 million. In practice, this might be redeployed to other patients with a resultant reduction in waiting times. There are then several non-monetised benefits on top, related to reduced delays and health gains.

**Case study 3 Ward discharge services following knee replacement (tramadol prescribed)**

Tramadol is an opioid painkiller used to treat moderate acute pain. Patients who have operations such as hip or knee replacements can benefit from the pain-relieving effects of Tramadol to help them complete the early stages of their rehabilitation.

Physiotherapists provide post-operative rehabilitation in hospital settings and also work in physiotherapy departments and in community settings providing care to patients recovering from injury and surgery. Good pain relief is essential to enable patients to undertake their early rehabilitation comfortably and get optimal benefits from physiotherapy.
Tramadol has recently been reclassified as a controlled drug, which means that whilst physiotherapists used to be able to prescribe this, they now cannot do so. If a patient receiving physiotherapy requires tramadol to give effective pain relief, then the physiotherapist must send

[24] Registrant snapshot - 1 April 2025 | The HCPC

the patient to see a doctor. This can mean that patients may temporarily stop their rehabilitation if they feel it is too painful, which can slow their progress down and delay their overall recovery.

If physiotherapists were once again able to independently prescribe tramadol, patients would be able to receive quicker access to the appropriate pain relief they required to support their treatment and rehabilitation. This would include moving the patient to an alternative simple painkiller as the post-operative pain settles. Patients would experience fewer delays in their progress and would need to make fewer visits to a range of professionals to obtain effective short-term pain relief.

The particular case study of care following a knee operation is a low-volume, high-impact prescribing scenario, with relatively low volumes of patients with post-operative pain which is poorly controlled. Tramadol is the assumed medication in this situation. The scenario also assumes that discharge is delayed under current prescribing rules, a situation potentially mitigated by the proposed reform.
Like the other case studies, the impact of reform involves avoiding referral and potential delay, but with the physiotherapist independent prescriber needing extra time to issue the appropriate prescription.

*Potential number of referrals affected*

| | |
|---|---|
| Number of physiotherapist independent prescribers (Apr 2025, HCPC database) | 2,905 |
| Of which, 80% work in specialisms which have pain management as the main driver of prescribing | 2,324 |
| Of which, 10% work in acute post-surgical wards | 232 |
| Typical caseload per physiotherapist per year (48 weeks x 26 per week) | 1,248 |
| Of which, 10% have poorly controlled pain and half of those involve delayed discharge (5% overall) | 62 |
| Total number of tramadol referrals required per year (232 x 62) | 14,400 |

*Impact on a per referral basis*

As with case studies 1 and 2, each avoided referral is estimated to provide an NHS benefit of £37 on a net basis (using the same calculation as previously shown).

Assuming a £37 monetised net positive benefit each time the proposed prescribing flexibility is allowed, with volume of around 14,400 per year, the total monetised benefit to the NHS is therefore over £0.5 million. In practice, this might be redeployed to other patients with a resultant reduction in waiting times. There are then several non-monetised benefits on top, related to reduced delays and health gains.

**Annex A.3**

**College of Operating Department Practitioners**
**Case Studies for PGD Proposal**

## Case study 1

I am an ODP who works in the role of a Resuscitation Practitioner as well as a Senior ODP in Anaesthetics & Recovery in an independent hospital where quite often there is no immediately available medical professional, therefore a great deal of responsibility is placed on the ODP.

There have been a number of occasions where administration of medicines under PGD would have been beneficial to patient care.
Anaesthetics: Ophthalmic lists with no medical practitioner apart from surgeon; proxymetacaine, midazolam, ondansetron.
Pain List: With no Anaesthetic Practitioner apart from procedural Doctor: midazolam, ondansetron, fentanyl, propofol (for procedural sedation for those qualified to sedate patients following Sedate UK guidance).

Recovery: When no medical practitioner available: morphine, paracetamol, naloxone, flumazenil, salbutamol, aspirin, GTN, NaCl 0.9%, ondansetron, metoclopramide, cyclizine, glycopyrrolate / neostigmine, sugammadex, propofol, hyoscine.

Resuscitation: In the absence of a Medical Practitioner: Adrenaline 1:1000 (IM), adrenaline 1:10,000, Glucose 10%, GlucaGen, NaCl 0.9%, GTN, aspirin, midazolam, amiodarone, atropine, salbutamol, tranexamic acid.
You will see that I have repeated some of these medicines for different circumstances, however their availability to be used under a PGD could expedite patient care while awaiting the attendance of a medical practitioner.

## Case study 2

I work at an Eye Infirmary which is a standalone Hospital. As part of my role when Primary nursing, which is some part of an everyday duty, I have to prepare patients for their day case procedure. This entails instilling a variety of eye drops that are directed under Patient Group Directions (PGD). Because I am not able to give these medications through (PGD) route, I have to ask our doctors to prescribe the medications, this becomes quite frustrating as quite a few of our list and clinics are Nurse lead so trying to find doctors to prescribe slows our lists/clinic up. Medication involved include as Eye Drops under (PDG): Tropicamide 0.5% Minims, Oxybupivicaine 0.4% Minims, Chloramphenicol 0.5%, Phenylephrine 2.5% / 10% Minims, cyclopentolate 0.5%.

## Case study 3

I am currently employed as Streaming and Triage clinician working between an Emergency Department and Urgent Treatment Centre employed within an NHS Teaching Hospital. The role involves initial streaming, triage and minor illness management of all age groups presenting.

Within this role initial clinical decision making, assessment and prompt initial clinical management is key. On a daily basis I have to request a prescription for simple analgesics such as paracetamol and ibuprofen. Simple antihistamines such as loratadine and reversal agents such as naloxone. Initial clinical assessment often involves children and adults presenting with breathing difficulties requiring salbutamol; again, where I need to request a prescription.

This delay not only affects immediate patient care but also distracts NMP or Doctors away from their tasks to allow me to carry out my job function. The impact this has on effective patient care delivery cannot be understated. Nursing, physiotherapy, pharmacist and paramedic colleagues can simply administer these drugs under the held organisational PGDs, in which at times I hold further clinical expertise and experience than other NMC or HCPC colleagues yet can't administer simply drug treatments.

**Case study 4**

I'm unique in that I'm a Ward Manager in an Acute Psychiatric Hospital. We don't have doctors on sight 24/7, so the inability to administer PGDs causes delays in our patients experiencing treatment.
From Paracetamol, Gaviscon, Ibuprofen, senna and macrogols to life saving medications suggest as adrenaline, novarapid, glucose and antibiotics.

The was the same in my previous role when I was a unit manager for same day emergency care unit. The inability to administer PGD meant delays to treatment, delays in discharge and a stretch on resources as I had to find a nursing colleague to give a PGD.

When I worked in pre op assessment, I was prohibited from giving MRSA prevention, pre op bowel clearance and vitamins.

**Case study 5**

I am a Critical Care Outreach Practitioner (ODP) Intensive Care Medicine, responding to sick and deteriorating patients across the hospital complex.

Regularly attending patients in hypotensive septic shock, and delays awaiting a prescriber to attend, to support with IV fluid management and inotropic commencement. (All fluids / Metaraminol / Noradrenaline)

Attending as an experienced ALS provider, to weekly cardiac arrests and being limited on the number of pharmacy interventions to adrenaline and amiodarone. (Atropine / Calcium / Insulin/Dex / Glucagon)

**Case study 6**

I currently work as a Resus Trauma Practitioner in a Major Trauma Centre. We are a team of ODPs, Nurses and Paramedics who provide care and treatment within the resus environment to critically unwell medical patients and all trauma patients who present in resus. The team also provide support to the wider hospital attending Massive Haemorrhage activations on the wards as well as paediatric cardiac arrests and medical assistance calls.

I can think of numerous occasions where having access to PGDs for antiemetics, analgesia, lidocaine, and Co-amoxiclav would have made a difference to patient experience and also patient comfort.

I have cared for a patient who was being nursed in a rigid trauma mattress and unable to mobilise as the results of their CT scan had not come back. They began vomiting and were rolled to their side in the mattress. Having been able to administer Ondansetron would have relieved these symptoms quicker than having to leave resus and find a doctor to prescribe this medication.

When performing arterial blood gases on patients there is evidence to suggest that best practice is to use a local anaesthetic (lidocaine), this makes the procedure a more pleasant experience for the patient and also gives the practitioner more confidence knowing they are going to cause less pain to the patient. This would also save time when closing simple wounds in resus and for inserting difficult cannulas using ultrasound.

I am aware of a team similar to mine who are made up of nurses who all have access to PGDs including Ondansetron, Co-amoxiclav, Morphine, Tranexamic acid, Paracetamol.

## Annex A.4

## Illustrative case studies for diagnostic radiographers

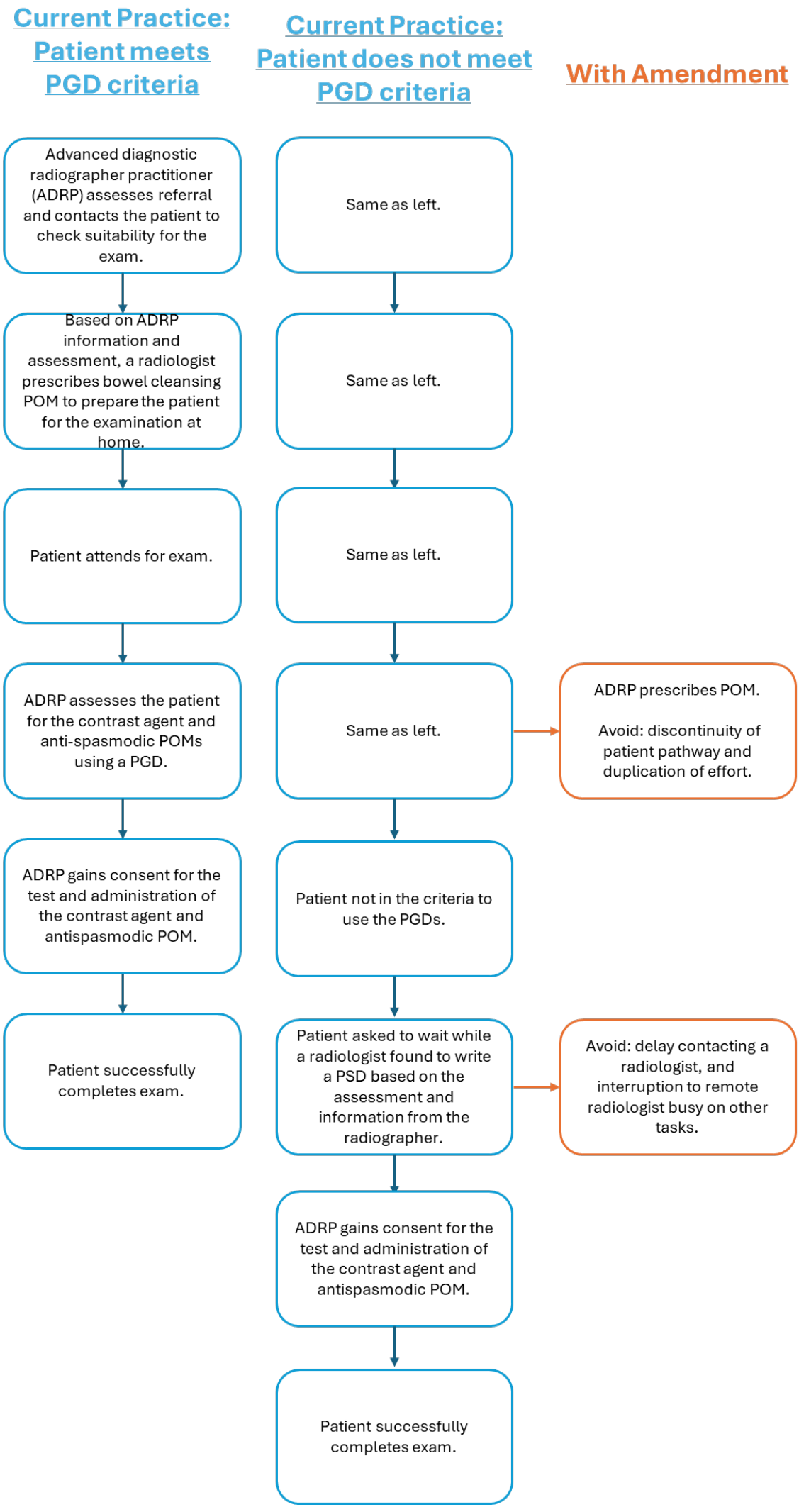
The SCoR has provided various case studies to help identify key benefits of the potential reform. These case studies help to illustrate where the reform could make the most difference and provide an illustrative basis for estimating the likely scale of impact.

Precise incidence of these cases is not specified at this time. However, they are assumed to occur frequently and impact a high number of patients.

### Case study 1 – CTC Pathway

A CT colonography examination is a CT scan that examines the large bowel for polyps and growths. Colorectal cancer is the 3rd most common cancer in both men and women in the UK[25]. In the NHS the use of CT colonography is an alternative imaging investigation of choice when a colonoscopy is incomplete, or the patient is unsuitable for colonoscopy. Before presenting for their appointment patients need to take bowel preparation. The laxatives used must be prescribed and given to the patient with the instructions on how to take them. On the day of the examination a smooth muscle relaxant may be given if indicated to decrease bowel movements that cause artifacts on the scan. Carbon dioxide or Air is used to inflate the bowel to improve visualisation of the bowel. Intravenous contrast media might be used during a scan to stage a neoplasm or to complete the assessment of the proximal colon after an incomplete colonoscopy. These examinations are increasingly radiographer led and performed in CDCs where there is no access to an onsite prescriber.

[25] Cancer Research UK, https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/bowel-cancer/incidence#heading-Zero


Current Practice: Patient meets PGD criteria
Current Practice: Patient does not meet PGD criteria
With Amendment
Advanced diagnostic radiographer practitioner (ADRP) assesses referral and contacts the patient to check suitability for the exam.
Same as left.
Based on ADRP information and assessment, a radiologist prescribes bowel cleansing POM to prepare the patient for the examination at home.
Same as left.
Patient attends for exam.
Same as left.
ADRP assesses the patient for the contrast agent and anti-spasmodic POMs using a PGD.
Same as left.
ADRP prescribes POM.
Avoid: discontinuity of patient pathway and duplication of effort.
ADRP gains consent for the test and administration of the contrast agent and antispasmodic POM.
Patient not in the criteria to use the PGDs.
Patient successfully completes exam.
Patient asked to wait while a radiologist found to write a PSD based on the assessment and information from the radiographer.
Avoid: delay contacting a radiologist, and interruption to remote radiologist busy on other tasks.
ADRP gains consent for the test and administration of the contrast agent and antispasmodic POM.
Patient successfully completes exam.

**Case study 2 - Ultrasound intervention**

A corticosteroid with local anaesthetic injection can help patients experiencing pain in a joint, tendon, or soft tissue. Pain can be debilitating, decreasing quality of life. Chronic pain profoundly impacts home and work life, as well as mental health. Growing demand means some patients wait from 8 weeks to a year for ultrasound intervention. Radiologists, physiotherapists, and diagnostic radiographers trained in ultrasound perform these examinations. Radiologists and physiotherapists are independent prescribers and can mix medicines to create a single injection into the joint. A radiographer sonographer using a PGD cannot legally mix two medicines under the PGD and must administer two separate injections or seek a PSD to allow mixing of the medicines.

A diagnostic ultrasound is performed to identify the cause of pain. The patient may be recalled for a radiologist/physiotherapist appointment if the radiographer sonographer has no access to a suitable medicine mechanism e.g. patient meets the PGD criteria or prescriber available for a PSD at the point of diagnosis. A local anaesthetic (lidocaine) is given to numb the area. A fine needle is used to inject into the joint guided by ultrasound. A radiographer using a PGD cannot give both a corticosteroid and local anaesthetic in one injection as medicines cannot be mixed.

## Current Practice: Patient meets PGD criteria

Advanced diagnostic radiographer practitioner (ADRP) sonographer assesses referral and accepts for image guided injection.

↓

Patient receives appointment.

↓

ADRP scans the patients and gains consent for joint injection.

↓

Patient meets PGD criteria.

↓

PGD does not allow mixing of medicines. Patient therefore needs two separate injections.

↓

Patient discharged with aftercare leaflet.

## Current Practice: Patient does not meet PGD criteria

Same as left.

↓

Same as left.

↓

Same as left.

↓

Patient does not meet PGD criteria. ADRP seeks a prescriber to prescribe the steroid and local anaesthetic.

→ ADRP prescribes medicines and performs joint injection.

↓

No prescriber available. Patient rebooked for a prescribers list.

→ Avoid: giving two separate injections.

Avoid: searching for prescriber.

↓

Patient waits for appointment slot.

→ Avoid: patient wait time.

↓

Patient attends for treatment after further diagnostic scan.

→ Avoid: further appointment.

↓

Patient discharged with aftercare leaflet.

## With Amendment

**Annex A.5**

This section provides fuller detail on how PGD development costs have been estimated. This is largely based on information received from the College of Paramedics. Cost per hour is estimated using the 2022/23 PSSRU Unit Cost Report which can be found here. The College of Paramedics advise that PGD development is estimated to take between 40 and 80 hours, depending on its complexity. Updates or revisions of existing PGDs can take between 20 and 40 hours. The below estimation is taken as the average scenario, but development costs can vary between £1,000 and £4,000 depending on complexity.

Estimated Time and Cost Breakdown:

| Role | Band | Time involved (hours) | Cost per hour (including on-costs) (£) | Total cost (£) |
|---|---|---|---|---|
| Specialist Pharmacist (lead author) | 8a | 20 | 42.99 | 860 |
| Medical Prescriber/Consultant | 8c or Consultant | 5 | 63.47 | 317 |
| Senior Nurse (clinical input) | 7 or 8a | 5 | 40.30 | 201 |
| Clinical Governance Lead (version control) | 8a | 5 | 42.99 | 215 |
| Administration (version control) | 4 or 5 | 3 | 22.00 | 66 |
| **Total (estimated)** | | **38** | | **1659** |

Once developed, the College of Paramedics estimate that it would take each individual between 30 minutes and one hour to read and understand the PGD. Most organisations will include some form of assessment. There is further organisational time involved as legally the individual paramedic must sign the PGD to ensure legal compliance and each organisation must monitor this.

We assume that the PGD development process is consistent across professions.

## Annex A.6 Glossary

| Term | Definition |
|---|---|
| **Exemptions mechanism** | Offer a straightforward mechanism to enable healthcare professionals to administer medicines promptly as long as this falls within their scope of practice and competence. |
| **First Contact Practitioner (FCP)** | A trained healthcare professional who provides a direct point of contact for patients without requiring a referral from a GP. |
| **Independent prescriber** | A healthcare professional who is authorised to independently prescribe medications within their scope of practice and relevant legislation. |
| **Patient Group Direction (PGD)** | Written instructions for medicines, including certain controlled drugs, to be supplied and/or administered by health professionals to patients who share the same medical condition or other features. They contain information about which health professionals can supply or administer the medicine, which patients they can see, and when they should involve a doctor. PGDs are not a type of prescription. |
| **Patient Specific Direction (PSD)** | Written instruction to administer or supply a medicine to a named patient who has been assessed by an authorised prescriber. |
| **Prescription-Only Medicines (POMs)** | These medicines normally need to be prescribed by a doctor or another prescriber before they can be administered or supplied to a patient. However, there are a range of exemptions from these restrictions which allow certain groups of health professionals to supply and/or administer medicines direct to patients. |