Global Policy Network

Global Medicines Policy Series 2025

Scaling Independent Prescribing in Community Pharmacy: A Policy Report

Health System: United Kingdom

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Abbreviations:

ARRS - Additional Roles Reimbursement Scheme

DPP - Designated Prescribing Practitioner

GP - General Practitioner

GPN - Global Policy Network

ILO - International Labour Organization

IP - Independent Prescribing

ICB - Integrated Care Board

ICS - Integrated Care Systems

NHS - National Health Service

PCN - Primary Care Network

RPS - Royal Pharmaceutical Society

UK - United Kingdom

WHO - World Health Organization

About Global Policy Network:

Global Policy Network (GPN) is an independent, not-for-profit policy institute committed to advancing evidence-informed dialogue in global health, education, and sustainability. By combining research, stakeholder insight, and applied policy analysis, GPN aims to shape thoughtful, actionable conversations on today's most pressing challenges.

Through roundtables, collaborative forums, and research publications, GPN convenes diverse voices from government, academia, civil society, and the private sector to bridge the gap between ideas and implementation. With an expanding network across the United Kingdom and internationally, GPN ensures that relevance, equity, and sustainability remain at the heart of systemic reform.

About the Series

The Medicine Policy series explores the evolving role of pharmacy in delivering integrated, community-based care aligned with National Health Service (NHS) priorities. Through a sequence of closed-door roundtables, insight reports, and collaborative forums, the series convenes senior leaders to identify practical steps for integrating and expanding pharmacy-led clinical services across the continuum of care (Royal Pharmaceutical Society (RPS), 2024; NHS Confederation, 2023).

Roundtable Two: *The Potential of Scaling Independent Prescribing in Community Pharmacy*

Hosted on 1st July 2025, 'The Potential of Scaling Independent Prescribing in Community Pharmacy' was the second in the United Kingdom (UK) Medicines Policy Series convened by GPN. Chaired by Shilpa Shah, CEO of Community Pharmacy North-East London, the discussion focused on the challenges and opportunities of embedding Independent Prescribing (IP) within NHS structures. Speakers included Reena Barai (Community Pharmacist and Owner, S.G. Barai Pharmacy), Jignesh Patel (Independent Prescribing Pharmacist and Chair, NEL ICB Pharmacy Provider Group), Lauren Reber (Workforce Development Pharmacist, NEL ICB), and Olivier Picard (Chair, NPA and CEO, Newdays Pharmacy Ltd.).

Delegates include representatives from NHS England, Integrated Care Boards (ICBs), Primary Care Networks (PCNs), community and hospital pharmacy, professional associations, consultancy, and academia. Discussions focused on commissioning gaps, Designated Prescribing Practitioner (DPP) capacity, inter-professional relationships, governance, and the prospects for scaling IP both through NHS pathways and private commissioning models. The insights and recommendations derived from this dialogue form the basis of this policy report.

Acknowledgements

We extend our sincere thanks to everyone who contributed their expertise to this roundtable. Chaired by Shilpa Shah, CEO of Community Pharmacy North-East London, the session benefited from her leadership and clarity of purpose.

We are especially grateful to our speakers: Reena Barai (Community Pharmacist and Owner, S.G. Barai Pharmacy), Jignesh Patel (Independent Prescribing Pharmacist and Chair, NEL ICB Pharmacy Provider Group), Lauren Reber (Workforce Development Pharmacist, NEL ICB), and Olivier Picard (Chair, NPA and CEO, Newdays Pharmacy Ltd.) for their thoughtful insights and commitment to advancing the future of community pharmacy.

We also thank the 26 delegates whose perspectives, shared under the Chatham House Rule, provided the lived experience that anchors this report. Their contributions have been instrumental in defining the next steps for embedding IP as a cornerstone of NHS primary care transformation (Community pharmacy roundtable, personal communication, July 1, 2025). This document reflects the collaborative effort of all involved.

We are also grateful to our GPN Fellows who supported this policy roundtable and report; they include Maureen, Bethlehem, Reeda and Clemence.

Foreword by Shilpa Shah, Chief Executive Officer, Community Pharmacy North-East London

Community pharmacy has been the first point of contact for many patients; it is accessible, trusted and embedded within local communities. As healthcare systems evolve, IP provides a powerful opportunity for pharmacy to step further into its clinical potential (Majercak, 2019; Piraux et al., 2024).

This roundtable brought together leaders and practitioners from across the UK to discuss what it will take to scale IP safely and effectively. The conversation was frank and forward-looking. Delegates shared examples of success, acknowledged the barriers still holding us back, and provided clear insights into how pharmacy can play a stronger role in the NHS of the future (Community pharmacy roundtable, personal communication, July 1, 2025).

For me, the message was clear: the profession is ready, but the system needs to keep pace. Community pharmacy should not be left on the margins of strategy and planning. We must be visible, integrated, and equipped to deliver care at a scale.

My hope is that this report not only reflects the lived experience of our colleagues but also inspires commissioners, policymakers, and decision-makers to act with urgency. Pharmacy has the people, the skills, and the ambition to make IP a reality for patients. It is time to unlock that potential.

Foreword by Ameneh Ghazal Saatchi, Founder & Chief Executive Officer, Global Policy Network

At GPN, our mission is to bring evidence, lived experience, and diverse voices to the centre of policymaking. The Medicines Policy Series was designed to ensure that health system reform is grounded in practical insights, not abstract ideals (NHS Confederation, 2023).

This second roundtable in the series focused on IP in community pharmacy, a topic both timely and essential. Across the UK, pharmacists are already demonstrating the transformative potential of prescribing when barriers are removed. Internationally, models from Scotland, New Zealand, Canada, and Australia have proven that pharmacy-led prescribing enhances access, efficiency, and workforce resilience (Hoti et al., 2011a, 2011b; Smith et al., 2020a, 2020b; Stewart et al., 2017; Tsuyuki et al., 2015; Walpola et al., 2024).

The discussions went beyond identifying challenges. Delegates defined clear actions: start commissioning IP nationally, stop marginalising pharmacy in policy frameworks, and scale proven innovations. GPN remains committed to ensuring that pharmacy is not a peripheral actor but a central pillar in the future of healthcare.

Executive Summary

Health and care systems worldwide are facing unprecedented strain, with rising demand, ageing populations, and a projected global shortfall of 10 million healthcare workers by 2030 (Boniol et al., 2022; World Health Organization (WHO) & International Labour Organization (ILO), 2023). Against this backdrop, IP by pharmacists is increasingly recognised as a practical and sustainable solution to expand patient access, strengthen primary care, and ease pressure on overstretched services (Majercak, 2019; Piraux et al., 2024).

In England, the NHS 10-Year Plan sets out a clear direction for neighbourhood health services, shifting care from treatment to prevention, from acute to community-based settings and from analogue to digital delivery (NHS, 2025; NHS Confederation, 2023). Community pharmacy IP is fundamental to realising this mission: improving access, optimising medicine use, supporting prevention and relieving pressure on general practice through better system integration. National bodies, including the RPS, have highlighted IP as essential to delivering the NHS 10-Year Plans objectives and to evolving community pharmacy contractual framework to support pharmacist-led clinical pathways (RPS, 2024). From September 2026, all newly registered pharmacists will qualify as independent prescribers, creating a rapidly expanding IP enabled workforce whose skills must be commissioned, supported, and fully utilised (NHS England, 2025; Piraux et al., 2024).

This report is written at a pivotal moment. The Medium Term Planning Guidance gives ICBs a clear mandate to commission community pharmacy IP services from 2026/27 (NHS England, 2025). In parallel, the national Community Pharmacy Independent Prescribing Pathfinder Programme, involving over 210 community pharmacies, is testing models that embed prescribing within minor illness, contraception, long-term condition management and deprescribing pathways (NHS England, 2025). Pathfinder sites are examining the digital, governance, and commissioning frameworks required for safe, scalable implementation, with an academic evaluation underway. Our roundtable builds on these policy and programme foundations, offering practical recommendations to support implementation and scaling at pace.

Delegates identified a set of persistent barriers preventing IP from reaching its full potential:

1. Commissioning gaps: trained prescribers remain underutilised without funded posts, weakening morale and slowing rollout (Stewart et al., 2017).
2. Shortages of DPPs; supervision bottlenecks risk undermining the training pipeline (Hoti et al., 2011b).
3. Pharmacy technician workforce shortages; lack of support capacity limits pharmacists' ability to focus on prescribing (Smith et al., 2020a, 2020b).

4. Variability in General Practitioner (GP) engagement; collaboration remains inconsistent, and community pharmacy services are relatively disparate. They are not routinely included within patient care pathways or embedded as part of an integrated primary care offer (NHS Confederation, 2023; Tsuyuki et al., 2015).
5. Cultural barriers: misconceptions about pharmacists' clinical expertise persist, eroding confidence in IP (Majercak, 2019; Stewart et al., 2017).

These challenges go to the heart of the NHS 10 Year Plan and the three critical transitions it outlines (NHS, 2025). Speakers warned that unless community pharmacy is positioned centrally within these transitions, it risks being left "on the margins of strategy and planning" (Pharmacy workforce lead, personal communication, July 1, 2025).

International experiences offered valuable lessons to overcome these barriers. Scotland's ring-fenced national funding secured rapid IP uptake (Stewart et al., 2017); New Zealand's investment in the pharmacy technician workforce freed pharmacists to focus on clinical prescribing (Smith et al., 2020a, 2020b); Australia addressed supervision bottlenecks through regional DPP hubs (Hoti et al., 2011b); and Canada's Alberta model demonstrated the benefits of embedding pharmacist prescribers directly into governance and primary care teams (Tsuyuki et al., 2015; Walpola et al., 2024). Together, these case studies confirm that systemic support, sustainable funding, and role clarity are critical to successful implementation (Piraux et al., 2024).

From the roundtable, three clear imperatives emerged for policymakers and system leaders:

- Start: Commission community pharmacy IP services nationally with dedicated funding, structured DPP networks (including digital supervision hubs), and expanded pharmacy technician workforce strategies; and fully include community pharmacy within national policy frameworks and workforce plans as a core part of the IP enabled primary care workforce (NHS England, 2025; Stewart et al., 2017).
- Stop: End restrictive service commissioning and payment models that confine pharmacy to narrow, transactional roles, and discontinue approaches that treat community pharmacy as an optional add-on rather than a strategic clinical partner (NHS Confederation, 2023; Smith et al., 2020a).
- Scale: Extend successful Pathfinder clinical models and private IP service models, embed pharmacists into neighbourhood care teams, integrating services as part of Integrated Care Systems (ICSs) care pathways positioning community pharmacy as the "front door" of primary care (NHS England, 2025; Tsuyuki et al., 2015).

Taken together, these recommendations outline a clear pathway for moving beyond piecemeal service commissioning and short-term pilots toward making IP a mainstream function of community pharmacy. By embedding IP as a cornerstone of the NHS 10-year Plan, patients can benefit from more timely access to care, clearer and more integrated care pathways, and reduced pressure on general practice and urgent care settings, while helping to build a more resilient, community-based workforce (NHS, 2025; NHS Confederation, 2023). The following sections of this report expand on these insights, drawing on delegate perspectives and international case studies to illustrate how independent prescribing can be scaled safely, sustainably, and equitably.

Key Insights from the Roundtable

1. Independent Prescribing must move from policy to practice

Pharmacists are completing IP training in growing numbers, but commissioning and governance lag far behind. Without funded posts, many prescribers remain unable to use their skills. One delegate cautioned, "We are producing prescribers, but the system has no clear place for them to go" (Community pharmacist delegate, personal communication, July 1, 2025). Scotland's experience shows that when funded IP posts are embedded in primary care, uptake and morale rise (Stewart et al., 2017).

2. Supervision bottlenecks limit training capacity

A shortage of DPPs, compounded by the absence of structured funding for supervision, was described as a persistent barrier to a successful implementation of IP into community pharmacy. Pharmacists spoke of long waits and personal financial costs to secure supervisors. "Unlike other clinical roles, we are left to negotiate supervision informally, and it simply isn't scalable," one participant remarked (Pharmacist delegate, personal communication, July 1, 2025). Australia's regional supervision hubs provide a replicable model for widening access and maintaining quality (Hoti et al., 2011b).

3. Integration depends on breaking silos with general practice

Collaboration with GPs was described as inconsistent; some areas demonstrated excellent collaboration, while others experienced obstructive relationships. This variability directly affects continuity of care. "Where the relationship is good, patients move seamlessly; where it isn't, they get stuck in the system," noted one delegate (Pharmacy workforce lead, personal communication, July 1, 2025). Canada's Alberta model, which structurally embeds pharmacists in primary care teams, demonstrates how governance frameworks and shared records can normalise collaboration (Tsuyuki et al., 2015).

4. The pharmacy workforce is broader than prescribers

Delegates repeatedly stressed the importance of pharmacy technicians as enablers of scalable IP. Without a strong pharmacy technician pipeline, pharmacists remain tied to dispensing and administration. As one participant put it, “Until we fix the pharmacy technician pipeline, IP will remain theory more than practice” (Community pharmacist delegate, personal communication, July 1, 2025). New Zealand’s investment in pharmacy technician career pathways freed pharmacists for clinical prescribing at scale (Smith et al., 2020a, 2020b).

5. Cultural recognition remains the hardest barrier

Misconceptions about pharmacists’ clinical competence persist among both policymakers and other professionals. This lack of recognition was described as “the hardest nail to crack.” Delegates emphasised evidence-led advocacy: publishing outcomes, showcasing patient impact, and ensuring pharmacy is visible in NHS strategy (Majercak, 2019). Canada and Scotland demonstrated that outcome-based campaigns can shift perceptions and secure trust (Stewart et al., 2017; Tsuyuki et al., 2015; Walpola et al., 2024).

Taken together, these insights underline a central truth: IP is not a marginal professional development exercise; it is a systemic reform. Unless commissioning, supervision, workforce planning, and inter-professional collaboration are addressed in a coordinated way, the NHS risks squandering the potential of a skilled and motivated cadre of pharmacist prescribers (NHS, 2025; NHS Confederation, 2023). By embedding IP into mainstream NHS strategy, with clear roles, sustainable funding, and robust governance, the health service can strengthen primary care, ease GP pressures, and deliver on the ambitions of the NHS Long Term Plan (NHS, 2025).

Introduction

Over the past decade, pharmacy in the UK has evolved significantly, shaped by NHS reforms, rising patient expectations, and mounting workforce pressures (NHS Confederation, 2023; RPS, 2024). Initiatives such as the Community Pharmacist Consultation Service and the Pharmacy First Service have positioned community pharmacists as the first point of contact for minor conditions. Diverting substantial volumes of patient consultations away from already-stretched GP practices and urgent care into pharmacies (NHS England, 2019). These services have elevated pharmacy visibility and enabled fuller use of community pharmacists’ clinical skills. Yet, despite this progress, full utilisation of the community's pharmacy workforce remains constrained by workforce shortages, fragmented commissioning arrangements, lack of

parity in access to clinical supervision, and uneven digital integration (Boniol et al., 2022; WHO & ILO, 2023).

The NHS 10 Year Plan (NHS, 2025) sets a clear ambition to shift care closer to home, expand preventative services, and strengthen integrated neighbourhood teams. At its core, the NHS 10 Year Plan is defined by three major transitions. First, from treatment to prevention: reducing demand on acute services by empowering patients to manage long-term conditions earlier and more proactively. Second, from acute to community-based care: rebalancing the system by strengthening primary care, community pharmacy, and local multidisciplinary teams to absorb more clinical activity that would otherwise escalate into urgent or hospital care. Third, from analogue to digital: modernising infrastructure and embedding interoperable digital tools, shared records, and decision support to improve efficiency, safety, accountability, and continuity of care across settings (NHS Confederation, 2023; RPS, 2024).

Community pharmacy, with its accessibility, reach, and high level of public trust, is uniquely placed to drive this transformation. A key enabler of that shift is the expansion and full deployment of IP. Scaling IP offers a practical route to widen access to clinical care, reduce pressure on urgent and unscheduled demand in primary care, and improve medicines optimisation for people with long-term conditions (Majercak, 2019; Piraux et al., 2024; Tsuyuki et al., 2015). The limiting factors are no longer primarily about pharmacists' clinical capability. Instead, the constraints now sit in commissioning design, lack of protected learning time, access to DPPs and supervision capacity, the availability of trained and empowered pharmacy technicians to release pharmacist time, and reliable access to shared patient records (Hoti et al., 2011a, 2011b; Smith et al., 2020a; Stewart et al., 2017). In other words, the model is clinically credible; the challenge is structural.

International experience reinforces both the urgency and the solvability of these issues. Scotland has shown that embedding IP roles directly within NHS-funded primary care teams, supported by dedicated national funding, accelerates uptake and improves morale (Stewart et al., 2017). New Zealand's workforce reforms demonstrate how strategic investment in pharmacy technicians allows pharmacists to focus on higher-value clinical prescribing activity (Smith et al., 2020a, 2020b). Australia's regional supervision hubs offer a scalable answer to DPP shortages, while Canada's Alberta model shows how integrating pharmacists into local governance structures strengthens continuity of care and normalises prescribing within the wider system (Hoti et al., 2011b; Tsuyuki et al., 2015; Walpola et al., 2024). Across these systems, the common pattern is clear: where supervision, funding, workforce planning, digital access, and governance are aligned, IP adoption is faster, safer, and more sustainable (Piraux et al., 2024; Walpola et al., 2024). These lessons point to a central conclusion for the UK: sustained investment in structured supervision, nationally coherent

commissioning, pharmacy technician pipeline development, and interoperable records is not optional but foundational.

Evidence within the UK already points in the same direction. The NHS Confederation (2023) found that systems investing more in community-delivered services achieved 15% lower non-elective admissions and 10% fewer ambulance conveyances, alongside reductions in emergency activity. This indicates that when capacity is genuinely moved into community settings, system pressure drops. Scaling IP within community pharmacy is therefore not just desirable for professional development; it is strategically necessary if the NHS is to manage demand, build workforce resilience, and protect access in the face of rising need (NHS, 2025).

This policy report presents the findings of the second roundtable in the UK Medicines Policy Series, convened on 1 July 2025 under the Chatham House Rule. The session, chaired by Shilpa Shah (CEO, Community Pharmacy in North-East London), took place at a pivotal moment for the profession. It brought together senior pharmacy leaders, NHS regional pharmacists, PCN leads, frontline community practitioners, clinical fellows, policy specialists, and international experts. The purpose was to examine how IP can be embedded at scale in community pharmacy, what is working, what is blocking progress, and what system changes are needed to accelerate safe adoption (Community pharmacy roundtable, personal communication, July 1, 2025).

The discussion captured the lived experiences of professionals already delivering or supervising IP. Including those operating in high-demand settings where access to GPs is strained, urgent care demand is rising. Participants explore how IP can strengthen prevention, reduce avoidable hospital pressure, and enable pharmacists to play a formal and accountable role in multidisciplinary neighbourhood teams (Carter et al., 2018; Piraux et al., 2024). Critically, they also highlighted the structural barriers that continue to slow progress: supervision and DPP capacity, commissioning fragmentation, limited pharmacy technician support, variable digital interoperability, and the absence of consistently funded protected training time (Hoti et al., 2011b; Smith et al., 2020a; Stewart et al., 2017).

Taken together, the roundtable's insights position community pharmacy not as an optional extension of NHS capacity but as a central pillar of the next phase of primary care transformation. The direction of travel is already clear: care closer to home, clinically confident pharmacists with prescribing authority, and a redesigned workforce model that allows pharmacy professionals to practice at the top of their licence. The task now is to align policy, funding, infrastructure, and workforce planning to make that vision real at scale (NHS, 2025; NHS Confederation, 2023).

Problems Faced in Community Pharmacy

IP in community pharmacy faces a series of interconnected structural, workforce, and cultural challenges. The roundtable discussions illuminated how these barriers are experienced in practice, exposing a persistent gap between professional ambition and system readiness. Delegates emphasised that, while enthusiasm for IP is strong, the lack of structural alignment and consistent support mechanisms continues to undermine delivery on a scale (Community pharmacy roundtable, personal communication, July 1, 2025).

Structural Gaps in Commissioning and Role Definition

A fundamental barrier is the lack of clearly defined, sustainably funded roles for community pharmacists who have completed IP training, limiting the impact and utilisation of their enhanced skills. As one participant remarked, "We've trained hundreds of prescribers, but without funded roles, these qualifications sit idle." The lack of a commissioning pathway risks demoralising the workforce and limits service expansion. Scotland's experience demonstrates that embedding funded prescribing roles within NHS primary care teams drives uptake and ensures smoother integration across the system (Stewart et al., 2017).

Closely linked to this is the risk of narrowing pharmacy's role to prescriptive or overly constrained service models. Several delegates cautioned that commissioning frameworks often define pharmacy services too rigidly, leaving little room for local innovation or responsiveness. "We are a dynamic and diverse profession, and our value lies in not being boxed in," emphasised a community pharmacist delegate (Community pharmacist delegate, personal communication, July 1, 2025). Their experience in balancing clinical service delivery with business realities underscored the importance of commissioning flexibility to reflect the diversity practice. International evidence, particularly from New Zealand, shows that broad, patient-centred commissioning models enable pharmacists to deliver more flexible and effective care (Smith et al., 2020a, 2020b; Walpola et al., 2024).

Inadequate Supervision and DPP Capacity

The shortage of DPPs, compounded by the absence of national supervision funding, represents a major bottleneck in training and practice. Many pharmacists rely on overstretched supervisors, creating inequities, and slowing qualification rates. One participant noted, "We can't scale prescribing if every pharmacist has to beg for a DPP" (Pharmacist delegate, personal communication, July 1, 2025). In Australia, national supervision hubs have provided a scalable, structured solution offering shared oversight and consistent access to supervision across regions (Hoti et al., 2011b).

Pharmacy Technician Workforce Shortages

Pharmacy technicians are critical to ensuring pharmacists can focus on clinical prescribing rather than administrative or dispensing tasks. Yet, shortages of pharmacy technicians driven by pay disparities and limited career progression opportunities continue to restrict efficiency. As one delegate put it, “Without pharmacy technicians, pharmacists are stuck firefighting instead of prescribing.” New Zealand’s national workforce strategy offers a valuable model, demonstrating how investment in pharmacy technician training and career pathways frees pharmacists for higher-level clinical work (Smith et al., 2020a, 2020b).

Fragmented Collaboration within Primary Care

Engagement between community pharmacy and general practice remains inconsistent across regions. While some areas report strong partnerships, others experience resistance or siloed working practices. “In some areas, GPs treat us as equals, but elsewhere the door is firmly shut,” one delegate explained (Pharmacy workforce lead, personal communication, July 1, 2025). Fragmentation in data-sharing and referral systems further compounds this issue. As another participant observed, “We can’t provide joined-up care if records are locked behind GP walls.” Internationally, the integrated care model in Alberta, Canada, demonstrates that when pharmacists are embedded within primary care teams with access to shared patient records referrals become seamless and patient outcomes improve (Tsuyuki et al., 2015; Walpola et al., 2024).

Policy and Planning Under-representation

Participants also highlighted that community pharmacy remains under-represented in national strategic frameworks. “Policy talks about primary care, but too often pharmacy is invisible in that conversation,” one delegate remarked (Clinical fellow, personal communication, July 1, 2025). This omission weakens advocacy for funding, marginalises pharmacy from workforce planning, and perpetuates its exclusion from key decision-making forums. In contrast, Alberta’s model integrates pharmacists directly into health system governance, ensuring their expertise informs planning and commissioning at the highest level (Tsuyuki et al., 2015).

Restricted Patient Eligibility and Referral Barriers

Overly restrictive eligibility criteria, such as limiting prescribing to patients with single conditions or narrow demographic groups, undermine the potential reach of IP services. “If criteria are too tight, we’ll miss the patients who need us most,” one participant noted (Community pharmacist delegate, personal communication, July 1, 2025). Lessons from New Zealand show that inclusive prescribing frameworks, designed around patient needs rather than rigid categories, expand access and improve equity of care (Smith et al., 2020a; Walpola et al., 2024).

Persistent Misconceptions and Trust Gap

Finally, cultural and perceptual barriers persist. Misunderstandings about pharmacists' clinical expertise continue to fuel resistance from some policymakers and health professionals. As one delegate stated, "The hardest nail to crack is myth-busting." Without targeted efforts to challenge these misconceptions, pharmacy risks being viewed as peripheral rather than integral to healthcare delivery. International experience from Canada and Scotland illustrates that publishing outcome data and patient impact evidence is the most effective way to build professional trust and public confidence in IP (Stewart et al., 2017; Tsuyuki et al., 2015; Walpola et al., 2024).

Solutions to the Problems

Scaling IP in community pharmacy requires coordinated reforms across commissioning, supervision, workforce development, integration, and professional culture. The roundtable discussions provided clear, pragmatic solutions drawn from international evidence and the lived experiences of practitioners within the NHS (Community pharmacy roundtable, personal communication, July 1, 2025).

Commissioning and Funding Reform

Strategic commissioning in this context is the move from short-term, activity-based or headcount reimbursement to multi-year, outcomes-based funding that commissions capability and capacity across settings. It includes standardised role frameworks, paid supervision (DPP), clear career and training pipelines (including pharmacy technicians), interoperable digital access, and equity-focused service specifications aligned to ICB priorities (NHS Confederation, 2023; Smith et al., 2020a, 2020b).

Delegates agreed that national commissioning frameworks with ring-fenced funding are essential to unlock IP's potential. Without sustainable commissioning pathways, prescribers remain unable to translate training into practice, leaving valuable skills underutilised. As one participant noted, "Without ring-fenced funding, IP is just theory such that people get trained but can't practise" (Community pharmacist delegate, personal communication, July 1, 2025).

To operationalise strategic commissioning, the NHS should:

- Establish multi-year funding envelopes for IP services, tied to measurable outcomes and population needs (NHS, 2025; NHS Confederation, 2023).
- Embed paid supervision (DPP) and protected learning time within contracts (Hoti et al., 2011b; NHS England, 2025).
- Fund pharmacy technician's workforce growth to release pharmacist capacity for prescribing (Smith et al., 2020a).

- Standardise role profiles and progression pathways across PCNs/ICSs (Smith et al., 2020b).
- Mandate shared-records access and minimum data sets for transparent reporting (NHS England, 2019; NHS England, 2025).
- Evolve ARRS from headcount reimbursement to include community pharmacy and outcome-focused commissioning where appropriate (NHS Confederation, 2023).

Scotland's Primary Care Fund provides a model for success, demonstrating how funded prescribing posts embedded within NHS teams can drive uptake, stabilise morale, and ensure continuity of service (Stewart et al., 2017). England's next phase of NHS workforce planning should replicate this approach by embedding IP roles directly into ICSs and ensuring sustained funding for supervision and clinical support (NHS, 2025; NHS England, 2025).

Expanding the Supervisory Workforce

The shortage of DPPs continues to hinder IP scale-up, particularly where supervision remains informal and unfunded. Delegates called for a structured, nationally supported system for supervision that does not depend on goodwill alone and that incorporates a pay-it-forward model where newly qualified independent prescribers progress along a staged pathway (practice supervisor → associate → DPP), with protected time and support, to supervise the next cohort (Hoti et al., 2011b; Piraux et al., 2024).

Internationally, Australia's regional supervision hubs provide a scalable template. By pooling supervisory capacity through collaborative regional networks and digital mentoring platforms, training access and quality assurance can be maintained efficiently (Hoti et al., 2011). The NHS should adopt a blended approach that includes regional DPP hubs, a national digital matching/monitoring platform, funded supervisory capacity, and a formal pay-it-forward pipeline to expand and sustain supervision at scale (NHS England, 2025).**Embedding Community Pharmacy in Primary Care**

Historically, primary care in England has been defined largely around GP. The landscape is now evolving towards the recognition that primary care also includes Pharmacy, Optometry and Dentistry within ICBs and neighbourhood teams (NHS Confederation, 2023). Adoption, however, is fragmented: some systems have embraced Pharmacy, Optometry and Dentistry integration with co-commissioned pathways and shared governance, while others remain predominantly GP-centric.

Integration emerged as a consistent theme. Community pharmacy must be recognised as an integral component of primary care, not an adjunct. Embedding IP roles within ICSs and PCN will improve coordination, referrals, and patient outcomes. As one

pharmacist noted, “We can’t be treated as outsiders if we’re expected to deliver inside the system” (Community pharmacist delegate, personal communication, July 1, 2025).

Canada’s Alberta model offers strong evidence that when pharmacists are fully integrated into primary care teams, both trust and efficiency improve (Tsuyuki et al., 2015; Walpola et al., 2024). England can achieve similar outcomes by:

- Mandating joint commissioning and service planning between PCNs and community-pharmacy providers (NHS Confederation, 2023).
- Enabling shared access to digital health records with role-appropriate permissions for all primary-care pharmacists (NHS England, 2019; Piraux et al., 2024).
- Establishing co-governance structures that bring GPs and pharmacists into the same ICB decision-making forums, with shared outcomes and accountability (Stewart et al., 2017; Tsuyuki et al., 2015).

These measures would reduce variation, strengthen professional relationships, and position pharmacists as equal clinical partners across the primary-care system.

Workforce Development Beyond Pharmacists

A sustainable IP service does not only depend on pharmacists, but on the wider pharmacy workforce, particularly on pharmacy technicians. Delegates repeatedly emphasised that pharmacy technicians are vital to operational efficiency, freeing pharmacists from dispensing to focus on clinical roles. As one participant observed, “Pharmacists can’t prescribe if we’re stuck checking boxes all day, pharmacy technicians are the key to freeing us” (Pharmacy workforce lead, personal communication, July 1, 2025).

New Zealand’s workforce strategy provides an instructive example: by investing in pharmacy technician training, clear progression pathways, and competitive pay structures, it successfully rebalanced workload distribution and improved retention (Smith et al., 2020a, 2020b). A similar approach within the NHS would enhance capacity, morale, and service sustainability (NHS, 2025).

Myth-Busting and Cultural Change

Finally, cultural change is central to unlocking IP’s full impact. Persistent misconceptions about pharmacists’ clinical expertise continue to create unnecessary resistance among policymakers and other professionals. Delegates called for coordinated public and professional education to challenge outdated views. As one participant remarked, “We don’t need more pilots to prove safety we need the system to believe what the evidence already shows.”

Evidence from Canada's and Scotland's experiences shows that publishing real-world outcomes and highlighting patient safety data can shift perceptions and secure confidence among both professionals and patients (Stewart et al., 2017; Tsuyuki et al., 2015; Walpola et al., 2024). The NHS, professional bodies, and industry partners should therefore invest in systematic evidence-sharing campaigns that showcase the quality and safety of pharmacist-led prescribing (Piraux et al., 2024).

Taken together, these solutions illustrate that IP is not simply an additional professional qualification, but a system-level reform requiring structural, cultural, and financial realignment. By embedding IP within the commissioning architecture, strengthening the supervision pipeline, investing in the pharmacy technician workforce, and promoting professional visibility, the NHS can move IP from aspiration to routine practice delivering safer, more accessible, and more efficient care for all patients (NHS, 2025; NHS Confederation, 2023).

The Role of the NHS 10-Year Plan

The NHS 10-Year Plan (NHS, 2025) is a unique opportunity to position IP not as a supplementary initiative but as a cornerstone of system transformation. The NHS 10-Year Plan sets out three major transitions: from treatment to prevention, from acute to community care, and from analogue to digital and community pharmacy is uniquely positioned to drive progress in each (NHS Confederation, 2023; RPS, 2024).

From treatment to prevention: Community pharmacists, as the most accessible health professionals, deliver early interventions, screening, vaccination, and lifestyle support. Through IP, they can also ensure timely medication reviews, supporting the diagnosis management of long-term conditions such as cardiovascular, renal, and metabolic disease. Optimising care delivery improving outcomes, and reducing avoidable hospital admissions (Carter et al., 2018; Piraux et al., 2024; WHO & ILO, 2023).

From acute to community care: By embedding IP services in neighbourhood teams, community pharmacies can divert demand from general practice and hospitals, expanding access to timely care. Evidence from NHS Confederation (2023) shows that systems investing more in community-based services achieved 14% fewer emergency admissions, underlining the impact of shifting care closer to home. As one delegate stressed, "Pharmacies are the front door to care, not hidden behind general practice" (Pharmacy workforce lead, personal communication, July 1, 2025).

From analogue to digital: Effective IP depends on digital system interoperability. Delegates noted that without full integration of community pharmacy into NHS digital systems, pharmacists remain "information poor," undermining safety and continuity.

Digital integration is therefore central to enabling pharmacy to deliver on the 10-Year Plan's ambitions (NHS England, 2019; NHS England, 2025).

Roundtable participants emphasised that fulfilling this vision requires more than pilots or goodwill; it requires structural reform. Three priorities were consistently highlighted:

Embedding pharmacists in governance structures: Independent prescribers must have representation at ICB and ICS decision-making tables to ensure medicines optimisation and prescribing services are built into system planning from the outset. International evidence, such as Alberta's model in Canada, demonstrates how embedding pharmacists in governance accelerates adoption and improves continuity of care (Tsuyuki et al., 2015).

Investing in workforce, digital infrastructure, and supervision: Scaling IP will require nationally funded DPP networks, sustained investment in pharmacy technician pathways, and digital tools to support interoperability. New Zealand's national workforce strategy, which strengthened the pharmacy technician cadre, is a model of how investment frees pharmacists to focus on prescribing (Smith et al., 2020a, 2020b).

Developing inclusive commissioning models: Pharmacy must not be boxed into narrow, transactional roles. Instead, flexible, equitable commissioning frameworks are needed to ensure consistent access across all regions, from urban to rural. Scotland's success, where fully funded IP posts were embedded in NHS primary care teams, demonstrates how sustainable funding and clear role definition drive both uptake and morale (Stewart et al., 2017).

Embedding IP within the 10-Year Plan is not just about scaling prescribing rights; it is about redefining pharmacy's place at the centre of patient-centred, preventive, and integrated care. By aligning commissioning, workforce planning, and governance reform, the NHS can ensure that IP becomes a mainstream pillar of its next decade of transformation.

Implementation Risks and Mitigation

While scaling IP in community pharmacy offers major opportunities, implementation is not without risks. Delegates highlighted several challenges that could undermine delivery, alongside strategies to mitigate them (Community pharmacy roundtable, personal communication, July 1, 2025).

1. Funding Sustainability

Without dedicated, long-term commissioning pathways, IP services will likely struggle to achieve financial viability. Pharmacists often bear supervision costs themselves, unlike other professions where national support exists. As one delegate noted, "We've trained hundreds of prescribers, but without funded roles, these qualifications sit idle."

Short-term pilots risk creating inequity and instability (Stewart et al., 2017; NHS Confederation, 2023).

Mitigation: Establish national commissioning frameworks tied to ICBs and secure long-term financial support for supervision. Scotland's experience, where government-funded prescribing posts accelerated uptake, shows that ring-fenced resources are critical (Stewart et al., 2017).

2. Workforce Shortages and Burnout

The global shortage of healthcare workers estimated at 10 million by 2030 (WHO & ILO, 2023) places additional strain on community pharmacy (Boniol et al., 2022; WHO & ILO, 2023). Limited pharmacy technician support exacerbates workloads, leaving pharmacists "firefighting instead of prescribing."

Mitigation: Expand pharmacy techniciantraining, recruitment and career progression pathways, as demonstrated in New Zealand's workforce strategy, which successfully redistributed responsibilities (Smith et al., 2020a, 2020b). At the same time, embed wellbeing and retention incentives for pharmacists to avoid burnout (NHS, 2025).

3. Variability in GP Collaboration

Uneven engagement between general practice and community pharmacy results in fragmented care. Some GPs treat pharmacists as partners, while others resist shared governance, leading to delays in referrals and patient access. One participant observed, "Where the relationship is good, patients move seamlessly; where it isn't, they get stuck in the system" (Pharmacy workforce lead, personal communication, July 1, 2025).

Mitigation: Formalise GP pharmacy collaboration within ICS frameworks, including shared digital records and joint governance. Evidence from Alberta, Canada, where pharmacists are embedded in primary care teams, shows that structural integration builds trust and continuity (Tsuyuki et al., 2015; Walpola et al., 2024).

4. Limited Patient Eligibility and Access

Strict prescribing eligibility criteria limits the real-world impact of IP. Restricting prescribing to narrowly defined patient groups undermine reach. A participant explained, "If criteria are too tight, we'll miss the patients who need us most" (Community pharmacist delegate, personal communication, July 1, 2025).

Mitigation: Revise eligibility frameworks to reflect patient complexity. Early pilots in Australia showed that broadening criteria allowed pharmacists to manage chronic conditions effectively while maintaining safety (Hoti et al., 2011a; Piraux et al., 2024).

5. Professional Identity and Inter-professional Resistance

Misconceptions persist that pharmacists lack clinical expertise for IP. These cultural barriers create resistance from some policymakers and health professionals. As one delegate reflected, “The hardest nail to crack is myth-busting” (Clinical fellow, personal communication, July 1, 2025).

Mitigation: Launch awareness campaigns and highlight outcome data to demonstrate IP’s safety and value. Evidence from Canada and the US Veterans Health Administration confirms that pharmacist-led prescribing delivers safe, effective care (Carter et al., 2018; Tsuyuki et al., 2015).

6. Policy Underrepresentation

Community pharmacies continue to be underrepresented in national health strategies. Delegates warned that pharmacy risks being left “on the margins of strategy and planning” unless explicitly included in the NHS Long Term Plan and Workforce Strategy (NHS, 2025).

Mitigation: Position community pharmacy as a cornerstone of population health in national policy. Embedding IP in the NHS 10-Year Plan and workforce strategies would secure visibility, funding, and sustainability (NHS Confederation, 2023; RPS, 2024).

Recommendations

To unlock the full potential of IP in community pharmacy, action is needed across commissioning, workforce development, governance, and cultural change. The roundtable identified the following priorities (Community pharmacy roundtable, personal communication, July 1, 2025).

1. Commissioning and Funding

The absence of funded posts means hundreds of qualified prescribers remain underutilised. From 2026 onwards, all newly qualified pharmacists will register as independent prescribers and a substantial proportion are expected to work in community pharmacy settings (NHS England, 2025; Piraux et al., 2024). To move beyond pilots, the NHS must introduce a national commissioning framework with ring-fenced recurrent funding. Scotland provides a strong case study, where funded IP posts embedded in primary care teams accelerated uptake (Stewart et al., 2017).

In parallel, the Additional Roles Reimbursement Scheme (ARRS) has enabled PCNs to recruit clinical pharmacists and pharmacy technicians, expanding medicines-optimisation capacity and access (NHS Confederation, 2023). However, deployment is uneven; funding is time-limited or inflexible, and integration with ICS workforce plans is variable. Commissioners should evolve ARRS from headcount reimbursement to strategic commissioning: multi-year funding, standardised role frameworks, and outcomes-based contracts aligned to ICB priorities, with explicit scope

to use ARRS to support IP posts in community pharmacies as well as general practice (NHS Confederation, 2023). Pharmacy input in PCNs sustainably reduces GP workload, improves medicines safety, and delivers system value (Carter et al., 2018). England should embed IP posts into NHS workforce plans and ensure sustainable funding streams tied to ICBs, preventing skills from being wasted (NHS, 2025).

2. Supervisory Infrastructure

Training pipelines are slowed by shortages of DPPs and lack of supervision funding. Australia's regional supervision hubs demonstrate how shared, system-level oversight can expand capacity and maintain quality at scale (Hoti et al., 2011b). To address these constraints, the NHS should establish a national, standardised DPP infrastructure comprising:

- **Regional DPP hubs** hosted at ICB level or within existing Training Hubs, providing coordinated allocation of supervisors, structured oversight, quality assurance, and governance across primary care, community, mental health, and acute sectors (Hoti et al., 2011b; NHS England, 2025).
- **A digital supervision and accreditation platform** to match learners with DPPs, monitor progress against prescribing competencies, standardise documentation, and enable remote supervision to improve efficiency and transparency (Piraux et al., 2024).
- **Funded supervisory capacity** with nationally mandated financial incentives and protected time for DPPs, embedded within commissioning frameworks and workforce budgets to ensure supervision is recognised, resourced, and delivered consistently.
- **Cross-professional supervision** models that formally expand DPP eligibility beyond traditional medical routes, building-on established training pathways for pharmacists and other non-medical prescribers. These routes already exist; however, without funded supervision time many eligible clinicians are unable to act as DPPs in practice. National policy should therefore couple competency-based eligibility criteria with clear funding mechanisms to unlock this latent supervisory capacity safely and consistently (NHS Confederation, 2023).

Together, this integrated DPP infrastructure would remove current bottlenecks, accelerate prescribing qualification pipelines, and support a high-quality, multiprofessional prescribing workforce aligned with future service and workforce transformation needs. Essential to support the existing pharmacist workforce to develop as independent prescribers (Piraux et al., 2024; Tsuyuki et al., 2015).

3. Pharmacy Technician Workforce

Pharmacy technicians are critical to efficiency, yet current shortages leave pharmacists' firefighting rather than prescribing. New Zealand strengthened its pharmacy technician cadre, freeing pharmacists for clinical care (Smith et al., 2020a, 2020b). The UK must invest in pharmacy technician training, recruitment, and retention. Creating career progression pathways and aligning pay structures to stabilise the workforce. Enabling pharmacists to focus on more clinical focused services, including prescribing (Smith et al., 2020a).

4. Integration into Primary Care Pathways

Relationships between GPs and pharmacists remain inconsistent, with some areas reporting excellent collaboration while others silo working and resistance. Canada's Alberta model shows that embedding pharmacists in governance structures enhances trust and collaboration (Tsuyuki et al., 2015).

To achieve consistent integration across England, the NHS should:

- Mandate joint commissioning and service planning**:** Require PCNs and community-pharmacy providers to co-design and commission medicines-related services, aligning roles, capacity, and outcomes across the system (NHS Confederation, 2023).
- Enable shared access to digital health records: Provide full, role-appropriate access to shared care records for all pharmacists working in primary-care settings to support safe, seamless decision-making and reduce duplication (NHS England, 2019; Piraux et al., 2024).
- Embed pharmacists in ICB governance and workforce planning: Ensure senior pharmacy leaders hold formal roles within ICB medicines optimisation, primary-care transformation, and workforce boards so that community pharmacy IP is explicitly reflected in local strategies, investment decisions and workforce plans (NHS Confederation, 2023; Stewart et al., 2017).
- Increase awareness of community pharmacy services amongst the public and primary care clinicians through coordinated communication strategies (RPS, 2024).

In parallel, the NHS and professional bodies should run public-engagement campaigns, publish evidence of IP impact routinely, and actively challenge inter-professional myths by showcasing success stories across the UK (Piraux et al., 2024; Walpola et al., 2024). These measures would strengthen professional relationships, establish pharmacists as equal clinical partners in primary care, and enable coherent, system-wide medicines for optimisation and patient care (Carter et al., 2018; Tsuyuki et al., 2015).

5. Service Flexibility and Scope

Community pharmacy risks being boxed into narrow, prescriptive models that stifle innovation. As one delegate put it, “Our value lies in not being boxed in” (Community pharmacist delegate, personal communication, July 1, 2025). New Zealand’s broad commissioning of patient-centred prescribing services demonstrates the benefit of flexibility (Smith et al., 2020a).

To unlock this potential, the NHS should:

- Design flexible, outcomes-based service specifications**:** commission against outcomes, clinical capability, and patient need rather than fixed activity lists (NHS Confederation, 2023; Smith et al., 2020a, 2020b).
- Enable local adaptation within a national framework**:** allow ICBs and PCNs to tailor models to local population-health priorities and integrate pharmacy services with wider pathways (NHS, 2025).
- Avoid restrictive, single-condition or pilot-only approaches to IP: position pharmacist IP as a core, scalable workforce capability, not a pathway-specific initiative (Hoti et al., 2011a; Stewart et al., 2017).

This shift toward flexible commissioning will enable community pharmacy to innovate, maximise its clinical contribution, and support system-wide transformation (NHS Confederation, 2023; Tsuyuki et al., 2015).

6. Public Trust and Cultural Change

Persistent misconceptions undermine confidence in pharmacists as prescribers. International evidence shows that patient-outcome data is the most powerful tool for trust building (Stewart et al., 2017; Tsuyuki et al., 2015; Walpola et al., 2024).

To address this, the NHS and professional bodies should implement a coordinated trust-building strategy that includes:

- **National public and professional engagement campaigns:** proactively communicate the role, training, scope and clinical impact of pharmacist prescribers to patients, the public and the wider healthcare workforce (RPS, 2024; Piraux et al., 2024).
- **Systematic publication of IP outcomes:** routinely publish comparable data on safety (e.g., incident rates), patient experience (Patient Reported Experience Measures), clinical outcomes (e.g., blood pressure control, HbA1c), service impact (e.g., GP appointment deflection, time-to-consult) and equity of access using a standardised minimum dataset for transparency (Carter et al., 2018; NHS England, 2025).
- **Active myth-busting and professional advocacy:** challenge outdated assumptions with evidence-based narratives, case studies and exemplars from

across the UK that showcase safe, effective, innovative pharmacist-led care (Majercak, 2019; Stewart et al., 2017; Tsuyuki et al., 2015).

A coordinated, evidence-led approach will strengthen confidence, support cultural change, and position pharmacist prescribers as integral contributors to modern multidisciplinary care (Piraux et al., 2024; Walpola et al., 2024).

Closing Discussion

The roundtable reaffirmed that scaling IP in community pharmacy is both an urgent necessity and a strategic opportunity for the NHS. IP offers a practical, evidence-based mechanism to relieve pressure on general practice, enhance continuity of care, and improve access for patients, particularly in underserved areas (NHS Confederation, 2023; Stewart et al., 2017; Walpola et al., 2024).

Success, as emphasised by the delegates, requires alignment across commissioning, governance, and workforce planning. Persistent structural gaps such as unfunded roles, shortages of DPPs, limited pharmacy-technician capacity, and fragmented collaboration with general practice must be addressed through deliberate policy reform and sustained investment (Hoti et al., 2011b; Smith et al., 2020a; Tsuyuki et al., 2015). International lessons are clear: Scotland's ring-fenced funding embedded IP roles in primary care and lifted uptake and morale; Alberta integrated pharmacists into governance and clinical teams; New Zealand and Australia strengthened technician pipelines and regional supervision hubs (Hoti et al., 2011a, 2011b; Smith et al., 2020a, 2020b; Stewart et al., 2017; Tsuyuki et al., 2015). Sustainable success follows when IP is built into system architecture rather than treated as an isolated pilot (NHS, 2025).

The NHS 10-Year Plan should now position IP as a mainstream, commissioned function of primary care, moving community pharmacy from transactional activity to a fully recognised clinical partner in prevention, early intervention, and population health (NHS, 2025; RPS, 2024).

Support future community pharmacy IP services

- Establish a nationally consistent commissioning framework for community pharmacy IP, moving beyond pilot-based and locally variable models to a coherent national approach with core IP specifications, minimum standards, and multi-year funding across all ICSs (NHS Confederation, 2023; NHS England, 2025).
- Align commissioning with the new Initial Education and Training of Pharmacists prescribing pipeline, so that services are commissioned to utilise the growing

cohort of IP-ready pharmacists from 2026 onwards, rather than reacting after the workforce arrives (NHS England, 2025).

- Create a funded national model for clinical supervision and DPP capacity. Develop structured, cross-sector supervision with regional hubs; incentivise DPPs; align governance with Health Innovation Networks, Health Education Institutes, or Training Hubs (Hoti et al., 2011b; Piraux et al., 2024).
- Build robust governance and assurance across all providers**.** Set clear expectations for clinical governance, escalation, peer review, audit, and accredited clinical environments; place community pharmacy within the same assurance structures as PCNs/provider collaboratives.
- Enable full digital interoperability and access to patient records. Mandate interoperable systems (shared care records, diagnostic access, results reporting) and fund Information Technology that support safe prescribing and information sharing (NHS England, 2019; NHS England, 2025).
- Integrate community pharmacy IP services into ICS clinical pathways**.** Embed pharmacy within urgent care, long-term condition, and prevention pathways; enable bidirectional referrals (GPs, NHS 111, urgent care); commission pharmacists to manage defined cohorts (e.g., hypertension, minor illness, complex medicines optimisation) (Carter et al., 2018; Tsuyuki et al., 2015).
- Invest in a sustainable workforce and training pipeline**.** Fund protected learning time, backfill, and advanced practice development aligned with career frameworks (Foundation, Advanced, Consultant) and retention incentives in community pharmacy (Smith et al., 2020a, 2020b).
- Commission diagnostics and point-of-care testing alongside IP**.** Fund Point of Care Testing equipment/consumables and access to investigations where clinically appropriate, expanding scope safely (Hoti et al., 2011a; Piraux et al., 2024).
- Reform contractual and funding models**.** Shift from volume-based payments to blended funding that recognises clinical time, follow-up, and case complexity; introduce tariffs/bundles for pharmacist-led IP episodes; provide capital for clinical infrastructure (NHS Confederation, 2023).
- Strengthen public and professional awareness through commissioning requirements**.** Embedding communication and engagement into commissioning requires participation in Multi-Disciplinary Team education and shared learning to build trust and normalise pharmacist-led prescribing (RPS, 2024; Walpola et al., 2024).

Delivering this agenda also depends on capable management and leadership. Recent analysis from The King's Fund and the University of Birmingham on why management matters to the NHS 10-Year Plan underscores the need for strong managerial capacity to

translate these recommendations into system-wide results (Smith et al., 2025) Effective leadership across the NHS England, ICSs and professional bodies will be essential to coordinate implementation, align incentives and steward change over time. With this combination of strategic commissioning, robust governance, sustainable planning, and committed leadership, IP can be embedded at the heart of the health system, strengthening workforce resilience, advancing equity, and delivering safer, patient-centred care across every community (NHS, 2025; NHS Confederation, 2023).

Attendees of Roundtable Two

The insights and recommendations of this report have been informed by a roundtable event which took place on **1st July 2025** under Chatham House Rule. A diverse group of **26 delegates** from across the pharmacy and health policy ecosystem shared their expertise and insights to inform this policy report (Community pharmacy roundtable, personal communication, July 1, 2025).

Figure 1: Roundtable 2 Participants Job Category

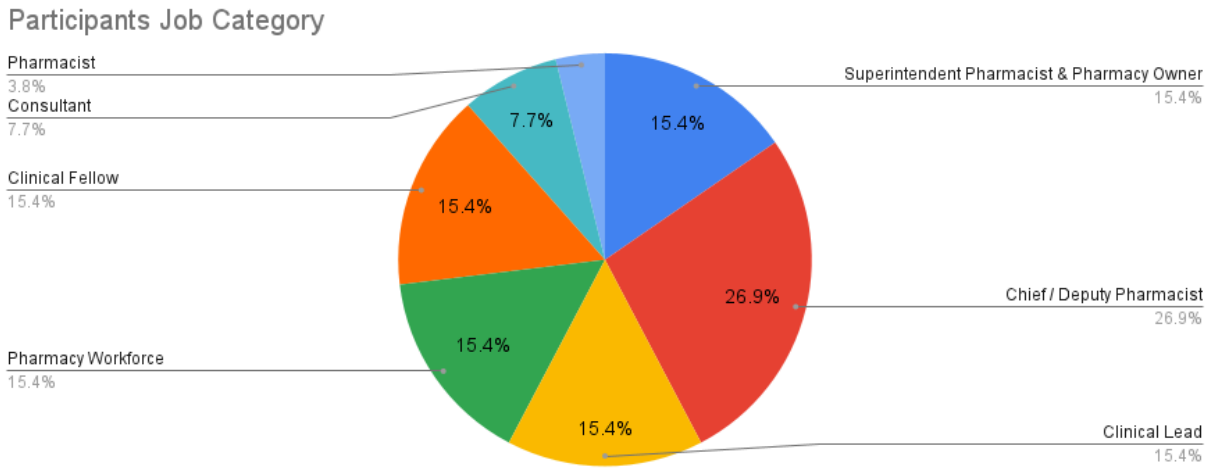
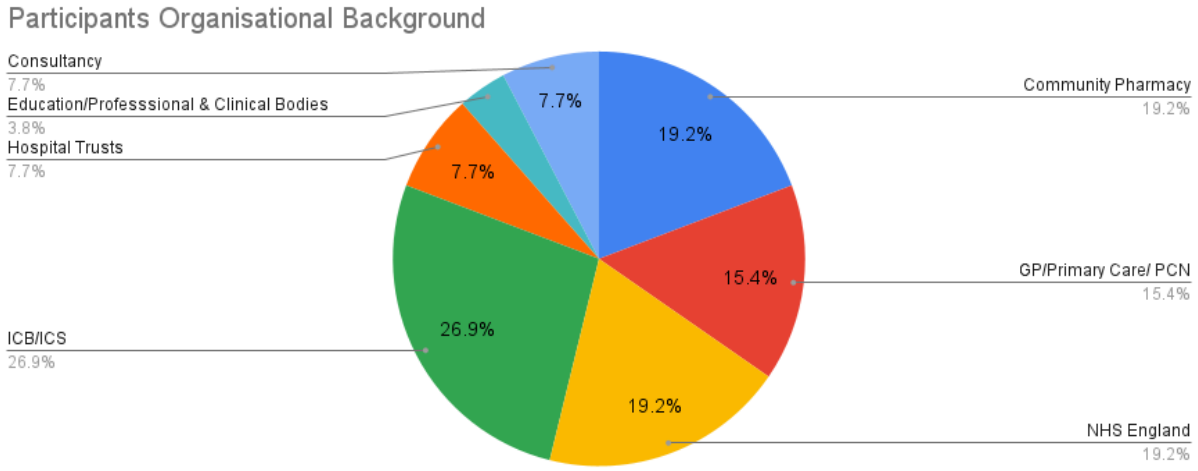


Figure 2: Roundtable 2 Participants Organisational Background



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3. **Lauren Reber**- Workforce Development Pharmacist, NEL ICB
4. **Jignesh Patel**- Independent Prescribing Pharmacist and Chair, NEL ICB Pharmacy Provider Group
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6. **Ravijyot Saggu-** Chief Pharmaceutical Officer's Clinical Fellow 21/22, NHS England; British Thoracic Society
7. **Nasrin Khan-** Head of Clinical Services and Chief Pharmacist, GPS Healthcare
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