Global Policy Network

Global Medicines Policy Series 2025

A Pharmacy Lens on Cardiovascular-Renal-Metabolic & Obesity- Integrated Neighbourhood Care: A Policy Brief

Health System: United Kingdom

info@globalpolicynetwork.com
www.globalpolicyetwork.com

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Executive Summary

The Global Policy Network (GPN) is an independent, global policy institute dedicated to promoting evidence-informed dialogue in global health, education, and sustainability. Through policy reports, forums, and collaborative programmes, GPN brings together voices from government, civil society, academia, and the private sector to identify solutions grounded in real-world experience. GPN's UK Medicines Policy Series examines the expanding role of pharmacy across the care continuum, identifying practical priorities that support integration, workforce development, and NHS reform. This is the sixth report in the series, convened on 22 November 2025 in Manchester, England, under the Chatham House Rule, bringing together sixteen senior leaders from across pharmacy and academia.

The roundtable participants discussed how integrated neighbourhood care models can apply a cardio-metabolic lens to strengthen primary care delivery and improve population health outcomes. The discussion focused on how pharmacy can move from a peripheral role to a fully embedded clinical partner within neighbourhood teams, with defined responsibilities in early identification, medicines optimisation, prescribing, patient education and multidisciplinary care coordination. Delegates stressed the need for comprehensive cardiovascular, renal, and metabolic (CVRM), and multiple long-term condition (MLTC)-focused care backed by a single, interoperable patient record, with suitable read-and-write access for pharmacy teams. They also highlighted the drawbacks of single-condition pathways.

The key barriers to achieving this vision are:

- Weak digital interoperability across care settings.
- Gaps in workforce preparedness and independent prescribing support.
- Operational misalignments between policy intent and frontline delivery.
- The challenge of shifting investment towards prevention at the neighbourhood level.

Priority actions include: National Health Service England (NHSE) and the Department of Health and Social Care accelerating the development of a single patient record and strengthening early CVRM care, and MLTC pathways; Integrated Care Boards (ICBs) establishing neighbourhood-level multidisciplinary teams with fully embedded pharmacy, and implementing operational readiness reviews before service launch; and on pharmacy leadership bodies coordinating structured independent prescribing readiness. Collectively, these steps position pharmacy not only as a delivery partner, but as a system-wide contributor to population health, early intervention and integrated care.

Recommendations

1) **NHSE and DHSC; Digital and Informatics Leads:**
   Invest in early-stage CVRM and MLTC treatment pathways and expedite the creation of a single, interoperable patient record. Support prevention, monitoring, and continuity of care by integrating patient-generated health data into clinical systems.

2) **ICBs:**
   Before launching new services, conduct operational readiness checks and establish multidisciplinary team (MDT) structures at the neighbourhood level with fully integrated pharmacies.

3) **ICB Pharmacy Directors and the Royal College of Pharmacy (formerly the Royal Pharmaceutical Society):**
   Support workforce competence, develop professional standards, establish regional pharmacy-led education platforms and a single Independent Prescribing (IP) preparedness programme. Commission accredited CVRM education pathways in partnership with universities, so pharmacists and wider teams can build consistent expertise in this integrated clinical area.

4) **Community and Primary Care Organisations:**
   Improve standards for communicating diagnoses to patients, especially for long-term and multimorbidity. Ensure explanations are understandable, culturally sensitive, and supported by written follow-up information. Assign consistent primary care teams to patients with chronic conditions to support long-term relationships, improve monitoring, and build trust. Develop structured referral and feedback systems among primary care providers, specialists, and community services to ensure seamless management of complex or multimorbid illnesses.

Achieving these objectives will necessitate strong leadership at both the national and ICB levels, structural transformation, and cultural shifts throughout the system. For pharmacy professionals to take the lead in medicines optimisation and broader NHS reform, they need to be fully supported and strategically integrated at both the ICB and national levels.

This report consolidates key insights and recommendations from senior pharmacy and academic leaders, moving beyond high-level policy ambition to address practical challenges within the CVRM and obesity care system. It sets out clear, actionable, system-level priorities that focus on integration, early intervention and neighbourhood delivery, areas that have not been explored in depth within earlier national reform frameworks such as the Darzi Review (Darzi, 2008), which laid the foundations for subsequent long-term NHS planning. The NHS 10 Year Health Plan (Department of Health and Social Care, 2025) and the Neighbourhood Health

Framework (Department of Health and Social Care, 2026), together with the 2025 General Practice and Neighbourhood Provider contracts, collectively set out a renewed national commitment to neighbourhood-based, prevention-focused care and the funding models that can enable this vision. By translating national intent into operationally relevant actions, the report provides a focused contribution to current CVRM transformation efforts.

Introduction

Over the past decade, cardiovascular disease (CVD) and related long-term conditions have continued to rise across the United Kingdom (UK), because of an ageing population, increasing multimorbidity, and widening health inequalities. CVD remains one of the leading causes of morbidity and mortality, with chronic kidney disease (CKD), hypertension, diabetes, and heart failure frequently coexisting in the same individuals (NHS England, 2023). UK-specific clinical and service model evidence increasingly supports the case for integrated CVRM pathways, with sources including the CVRM Centre and the National Cardiometabolic and Renal Network demonstrating how CVRM conditions overlap clinically and require integrated care approaches (CVRM Centre, 2025; British Journal of Cardiology, 2026).

The scale of this challenge is significant: approximately 7.6 million people in the UK are living with CVD, 3.5 million with CKD, and an estimated 5 million with diabetes, of which 90% is type 2 (Fernando, 2024). These conditions are inextricably linked — half of all patients with CKD stages 4–5 have CVD, cardiovascular mortality accounts for 40–50% of deaths in this group, and one third of adults with diabetes in the UK die from heart or circulatory disease (Fernando, 2024). Siloed, condition-by-condition management, therefore, fails to reflect the biological reality of how these diseases interact (Fernando, 2024).

National policy increasingly calls for integrated, neighbourhood-based care. The NHS 10 Year Health Plan (Department of Health and Social Care, 2025) prioritises prevention, stronger primary and community care, and a shift toward early intervention, digital capability, and population health management. The Neighbourhood Health Framework (Department of Health and Social Care, 2026) provides the most concrete expression of this ambition, setting out governance models, common outcome metrics, and financial incentives to support multidisciplinary neighbourhood teams, with community pharmacy explicitly recognised as a key partner in delivering neighbourhood health outcomes equitably. Cardiovascular disease and related conditions have been recognised as priority areas for prevention and risk reduction, due to their avoidable hospital admissions and long-term costs.

The Community Pharmacy Independent Prescribing Pathfinder Programme has demonstrated pharmacy's expanding clinical potential, testing cardiovascular service models, including hypertension management, lipid optimisation and atrial fibrillation, across ICBs and establishing a practical framework for the future of prescribing-based pharmacy services (NHSBSA, 2024). The Medium Term Planning Framework has

asked ICBs to begin rolling out local prescribing-based services, and the Strategic Commissioning Framework sets out how ICBs should move toward outcomes-focused, population health-oriented service design (NHS England, 2025).

Pharmacy professionals can play a central role in cardiovascular risk management and long-term condition care because they are accessible, clinically skilled, and in frequent contact with patients. Community pharmacies are also key access points for people who rarely use other parts of the health system, enabling earlier identification of cardiovascular risk factors and more consistent management of established disease. Their reach into deprived and underserved communities positions them as a natural partner within place-based neighbourhood frameworks. However, pharmacy's contribution to cardiovascular prevention and MLTC care remains limited, often constrained by service design, workforce readiness, and fragmented data.

The shift toward neighbourhood care has brought to light new operational and governance challenges. Integrated Care Systems (ICS) and ICBs face issues with delivering population health outcomes through communication across sectors, as practical mechanisms for joint decisions and accountability, as well as service coordination, have remained poorly developed in many ways (Edwards and Lewis, 2024). For pharmacists, this causes uncertainty around role definition, clinical responsibility, and integration within multidisciplinary teams. With no clear pathways, interoperable data, and supportive governance structures, the potential contribution of pharmacy to cardiovascular risk management may go unrealised.

Roundtable six unpacked these issues through a pharmacy lens, focusing on cardiovascular disease, MLTC, and integrated neighbourhood care. Moving beyond earlier integration debates, this pharmacy-led, system-focused roundtable sought to pinpoint the concrete governance, workforce, and digital enablers required to position pharmacy at the heart of cardiovascular and neighbourhood care. Seven themes, detailed below, reflect both the significant potential of pharmacy within neighbourhood CVRM care and the structural barriers that continue to limit it (Fuller, 2022; NHS England, 2025; Department of Health and Social Care, 2026; NICE, 2026).

Persistent Challenges and Strategic Priorities

The NHS 10 Year Health Plan signals a clear direction of travel, but CVRM and MLTC care present specific, interconnected challenges that require targeted action.

Workforce Challenges

Research consistently highlights pharmacy workforce shortages, retention pressures, and rising workload, with evidence linking expanded clinical duties and changing expectations to lower job satisfaction and poorer retention (Homayounifar et al., 2025). Persistent barriers to sustainability include challenging working conditions,

limited professional recognition, regulatory complexity, and evolving competency needs (Meilianti et al., 2024), alongside wellbeing risks driven by business-led performance metrics, reduced autonomy, and increasing service demand that contribute to stress and burnout (Schommer et al., 2022). Equity and inclusion research in England also reports differences in professional experiences by gender and race, alongside national efforts to promote more inclusive workforce practices (Thomson and Ibrahim, 2024).

Implications for Cardiovascular Risk Management

Workforce instability disrupts continuity, risk management, and follow-up for patients with multimorbidity. Effective cardiovascular prevention depends on consistent medication optimisation, monitoring, and engagement. High turnover, burnout, and limited learning time undermine safe prescribing expansion and weaken neighbourhood-based cardiovascular care. The Independent Prescribing Pathfinder Evaluation (2025) further shows that prescribing capability requires not just qualification, but protected learning time, structured supervision, mentoring, and supervised experiential learning within multidisciplinary teams (NHS England, 2025).

Operational and Financial Pressures

Digital and operational hurdles have also been reported. Community pharmacy digital systems remain insufficiently linked with general practice and secondary care, with limited interoperability affecting referrals, clinical data sharing, and service delivery (Tancock et al., 2023). Continued funding restrictions have constrained pharmacies as they have extended their involvement in contraception, blood pressure monitoring, and medication support (The Pharmacist, 2025).

Expansion of Scope of Practice

Policy documents published after 2022 reflect a formal extension of pharmacists' area of practice, including educational reforms that promote independent prescribing roles. However, these publications also highlight the importance of supporting workforce infrastructure, training capacity, and governance structures to meet expanded duties. No equivalent accredited education infrastructure currently exists for CVRM as an integrated clinical area, unlike in diabetes care and respiratory medicine, where formalised postgraduate pathways are well established (Diabetes UK, 2025; UWE Bristol, 2025).

Key Insights

1. Fragmented Data and Pathways Prevent Effective CVRM and Neighbourhood Care

The need for a national, interoperable single patient record was stressed by the delegates, who highlighted the lack of communication and transparency between primary and secondary care regarding patients' data and diagnoses. If unresolved, this prevents accurate risk stratification, early detection, and continuity of care, particularly for patients with CVRM conditions, who are often managed across multiple settings. Delegates identified cases where a diagnosis is apparent in one section of the system but not in another, hindering appropriate risk stratification, early identification, and continuity of care.

2. Multimorbidity Requires Holistic, Not Single-Disease Pathways

Delegates voiced concern that the healthcare system remains organised around single conditions, even though most patients live with multiple, interacting risks. They noted that patients often must repeat their story at every appointment, while multimorbidity frequently spans cardiovascular, renal, and mental health needs. As a result, people with cardiovascular conditions can move between cardiology, nephrology, diabetes services, general practice, and community care without a single, comprehensive plan. This fragmentation drives duplication, waste, and avoidable harm, and it can delay or prevent early intervention when each condition is managed in isolation. A related concern raised in the roundtable is the continued use of single-condition hospital coding, where a patient's episode is coded against one primary diagnosis and their intersecting CVRM conditions may not be captured — limiting risk stratification (Rowe et al., 2025; Peng et al., 2017), skewing commissioning data (Queirós et al., 2024), and leaving patients with multimorbidity under-recognised in the system (Kuan et al., 2025). Delegates therefore suggested a shift towards shared assessment models and holistic care planning.

3. Workforce Education and IP Readiness Vary Across Settings

Pharmacists explained large degrees of variation in capability, confidence, and training. Many felt underprepared to manage complex, multimorbidity cases in primary care. Delegates recognised the urgent need for structured regional training frameworks. This would include continued professional development, multidisciplinary exposure and support structures for independent prescribing. It was emphasised that prescribing capability will not succeed without protected learning time, clinical supervision, and practical experience in team-based care. Evidence from the Independent Prescribing Pathfinder Evaluation (2025) confirms that inconsistent access to these supports negatively affects pharmacist confidence, increases perceived clinical risk, and limits safe integration into primary care teams (NHS England, 2025).

Embedding these supports is essential to enable primary care pharmacists to develop safely, providing structured mentorship and supervision while addressing skill gaps in managing multimorbidity, interpreting complex cases, and communicating effectively with patients.

4. Operational Barriers Undermine National Policy Intent

The roundtable emphasised that ICBs should establish operational readiness checks before implementing new services. Delegates described a recurring pattern in which the service model set out in policy does not match operational realities. Examples included inconsistent pathways, unclear referral mechanisms, and significant workload shifts that were not anticipated in the original design. Pharmacy First was widely cited as evidence that implementation must be co-designed with those delivering care. Delegates also raised concerns about the NHS Community Pharmacy Hypertension Case-Finding Service, where lower-than-expected uptake has left a significant proportion of adults with undiagnosed hypertension, increasing longer-term cardiovascular risk and downstream workload (Tsuyuki et al., 2025). Participants also noted a perception of rushed rollout and weak alignment between GP practices and community pharmacies as persistent system weaknesses. Operational readiness checks could help avoid repeat failures by improving operational alignment and ensuring referral pathways are clearly understood by both pharmacies and GP practices.

5. Left Shift Requires Investment, Not Reallocation

The need to shift from activity-based funding to outcome-driven investment is evident. Activity-based funding has led to dialysis costs being unsustainable. However, outcome-driven prevention investment cannot be conducted simply by reallocating existing budgets from acute care to primary care. To ensure resources are targeted effectively and equitably, national risk stratification and prioritisation frameworks are needed. These would support consistent identification of high-risk groups and guide where prevention investment should be directed to deliver measurable outcomes. Delegates highlighted that making this transformation will necessitate financial structures that reflect the long-term value of prevention, both for patients and for the wider health and care system (Department of Health and Social Care, 2025).

6. Patient Understanding and Engagement Are Critically Weak

Delegates raised serious concerns about patient awareness. Many people with chronic kidney disease (CKD) or cardiovascular risk factors do not know they have these conditions or do not understand the implications., consistent with the NICE (2021) finding that a significant proportion of patients with CKD are unaware of their diagnosis or its clinical consequences. Pharmacy professionals described the emotional

and clinical burden of communicating diagnoses that were not previously explained, consistent with findings that highlight the stress and burnout associated with delivering complex clinical information without proper support (Schommer et al., 2022). There is a need for redesigned communication standards and shared decision-making tools, and a critical gap in community-level education structures (Community Pharmacy England, 2025). Delegates also called for broader access to early diagnostic testing and public health campaigns targeted at groups at higher risk of undiagnosed hypertension and kidney disease, including Black and South Asian communities (NHS England, 2019).

7. Neighbourhood Integration Depends on Relationships and MDT Learning

Delegates outlined effective models, for example, heart failure academies and neighbourhood teams, where multidisciplinary learning enhances outcomes. These models operate on trust, shared understanding and sustained communication. Local relationship development is vital for integrated cardiovascular care. Delegates argued that neighbourhood teams cannot succeed without operational governance and protected time for joint working. It is crucial for neighbourhood teams that require governance to receive funding and engagement frameworks to assist with local community pharmacy-GP-ICB communication (Edwards and Lewis, 2024).

Recommendations

The following recommendations are directed at key stakeholder groups.

NHS England and DHSC: Multimorbidity and Integrated Pathways

- Accelerate implementation of interoperable shared care records, including read/write access for community pharmacy.
- Commission integrated assessment templates that support combined CVRM risk stratification.
- Support routine multidisciplinary case reviews for high-risk or MLTC patients at neighbourhood level.
- Promote unified care plans with coordinated follow-up across primary, community and specialist services.
- Review hospital coding standards so co-occurring CVRM conditions are captured alongside a primary diagnosis.

NHSE, Digital and Informatics Leads: Digital Integration, Data Quality and Interoperability

- Accelerate the implementation of interoperable shared care records with read/write access to community pharmacy.
- Ensure pharmacy data (e.g., blood pressure, prescribing decisions) is visible across care settings.
- Align neighbourhood care models with national digital programmes.
- Improve data standards before expanding the use of artificial intelligence or machine learning tools.

ICB Pharmacy Directors and the Royal College of Pharmacy (formerly the Royal Pharmaceutical Society): Workforce Development, Education and Independent Prescribing

- Fund protected learning time and supervision for pharmacist prescribers.
- Provide structured regional IP readiness programmes.
- Ensure pharmacists have access to diagnostic systems and shared records.
- Develop national frameworks for mentoring and wraparound support.
- Standardise supervision expectations across regions.
- Support workforce wellbeing alongside clinical development.
- Commission accredited CVRM education pathways, short courses, diploma programmes or postgraduate modules, in partnership with universities.

DHSC, NHS England and ICBs: Funding Constraints, Left Shift Debates and Resource Allocation

- Provide dedicated prevention funding, not just reallocated budgets.
- Support national risk stratification frameworks to prioritise high-risk cardiovascular and renal patients.
- Offer clearer national guidance on realistic delivery expectations.
- Consider pooled prevention budgets or neighbourhood innovation funds.
- Target investment toward patients at highest cardiovascular and renal risk.
- Ensure the National Institute for Health and Care Excellence (NICE) guideline implementation is properly resourced.

Community and Primary Care Organisations: Operational Realities in Primary and Community Care

- Introduce an operational readiness checklist before launching new services.
- Co-design services with general practice, community pharmacy, and ICB teams.

- Clarify referral routes, governance arrangements, and workload implications in advance.
- Build feedback mechanisms to improve implementation after rollout.
- Improve standards for communicating diagnoses, especially for multimorbid and long-term conditions, ensuring explanations are understandable, culturally sensitive, and supported by written follow-up.
- Introduce routine mental health screening for patients diagnosed with CKD or multiple cardiovascular risk factors.

Policy Changes: What Do We Stop and Start Doing?

Stopping Existing Policy Approaches

1. **Short-term Commissioning and Siloed Deployment**
   Short-term pilots and time-limited funding remain the default for pharmacy commissioning, yet most end without long-term adoption, undermining workforce stability and service continuity. Pharmacists continue to be deployed in sector-specific silos, generating role confusion, duplication, and barriers to coordinated care.

2. **Fragmented Digital and Information Systems**
   Lack of interoperability between pharmacy, GP, and hospital systems restricts access to shared clinical information and reinforces pharmacy's disconnection from integrated care. Fragmented records remain a structural barrier to continuity and safe medicines management.

Starting New Policy Approaches

1. **Embedding Pharmacists Within Integrated Care Pathways**
   Effective models embed pharmacists, including independent prescribers, within multidisciplinary teams, underpinned by defined roles, shared governance, and clear care pathways.

2. **Supporting Expanded Scope of Practice**
   Role expansion must be matched by investment in training, supervision, and governance infrastructure to ensure safe and sustainable implementation. This includes commissioning accredited CVRM education for pharmacists and allied health professionals.

3. **Improving Access To Shared Patient Records**
   Interoperable records are a prerequisite for integrated pharmacy services, enabling timely access to medicine histories and clinical information across care settings.

4. **Formalising Interprofessional Collaboration**
   Structured collaboration frameworks and interprofessional education are needed to embed pharmacists meaningfully within multidisciplinary neighbourhood care teams.

Conclusion

These shifts mark a move away from fragmented, time-bound models toward long-term, system-owned pharmacy integration across cardiovascular and neighbourhood care.

CVRM conditions and MLTC represent a growing challenge for the NHS. Integrating pharmacy expertise within neighbourhood care models, supported by interoperable data systems, workforce development and operational alignment, will be critical to improving prevention, patient outcomes and system sustainability.

Attendees of Roundtable 6

This brief's insights and recommendations are informed by a roundtable convened on 22 November 2025 in Manchester, England, under the Chatham House Rule. Sixteen participants spoke from the perspective of senior leaders in pharmacy and academia.

Abbreviations

CKD - chronic kidney disease

CVD - cardiovascular disease

CVRM - Cardiovascular, Renal, and Metabolic

DHSC - Department of Health and Social Care

GP - General Practitioner

GPN - Global Policy Network

ICB - Integrated Care Board

IP - Independent Prescribing

MDT - Multidisciplinary Team

MLTC - Multiple Long-term Conditions

NHS - National Health Service

NHSE - National Health Service England

NICE - National Institute for Health and Care Excellence

PCN - Primary Care Network

UK - United Kingdom

Acknowledgements

Global Policy Network extends its gratitude to the invited speakers and all delegates who contributed to this roundtable. The experience and reflections shared by participants helped shape the key findings and recommendations in this brief.

References

1. British Journal of Cardiology (2026). CardioRenal Forum ASM: Working together to meet future needs in cardiorenal medicine. Available at: https://bjcardio.co.uk/2026/02/cardiorenal-forum-asm-working-together-to-meet-future-needs-in-cardiorenal-medicine/.

2. Community Pharmacy England (2025) *Neighbourhood health and integrated neighbourhood teams*. Available at: https://cpe.org.uk/lpcs-and-local/local-nhs-structures/neighbourhood-health-and-integrated-neighbourhood-teams/ (Accessed: 2 March 2026).

3. CVRM Centre (2025) *CVRM Centre*. Available at: https://www.cvrmcentre.co.uk/ (Accessed: 10 February 2026).

4. Department of Health and Social Care (2025) Fit for the future: 10 Year Health Plan for England. Available at: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-accessible-version (Accessed 10 April 2026).

5. DHSC & NHS England (2026). Neighbourhood Health Framework. Available at: https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework.

6. Diabetes UK (2025) Diabetes courses for healthcare professionals. Available at: https://www.diabetes.org.uk/for-professionals/learning-and-development/training-courses/courses-hcps (Accessed: 5 May 2026).

7. Edwards, N. and Lewis, R. (2024) *Integrated neighbourhood teams: lessons from a decade of integration*. London: Nuffield Trust.

8. Fernando, K. (2024) 'What links cardiovascular-renal-metabolic conditions?', *Practice Nurse*, 54(1), pp. 10–13.

9. Fuller, C. (2022) Next steps for integrating primary care: Fuller Stocktake report. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf (Accessed: 10 April 2026).

10. Homayounifar, F., et al. (2025) 'Global barriers to integrating community pharmacists into primary healthcare: a scoping review', *Journal of Primary Care & Community Health*, 16, pp. 1–12.

11. Kuan V, et al. (2025) Robustly measuring multimorbidity using disparate linked datasets. Communications Medicine. Available at: https://doi.org/10.1038/s43856-025-00995-4 (Accessed: 5 May 2026).

12. Meilianti, S., et al. (2024) 'Pharmacy workforce challenges: a narrative review', *Human Resources for Health*, 22, Article 67.

13. National Institute for Health and Care Excellence (2021) *Chronic kidney disease in adults: assessment and management (NG203)*. London: NICE.

14. NHS England (2019) *Health inequalities*. Available at: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/ (Accessed: 5 March 2026).

15. NHS England (2023) *Cardiovascular disease (CVD)*. Available at: https://www.england.nhs.uk/ourwork/clinical-policy/cvd/ (Accessed: 2 March 2026).

16. NHS England (2025) *2025/26 priorities and operational planning guidance*. London: NHS England.

17. NHS England (2025) *Independent Prescribing in Community Pharmacy Pathfinder Programme: transition and future direction*. London: NHS England. Available at: https://www.england.nhs.uk/long-read/independent-prescribing-community-pharmacy-pathfinder-programme-transition-future-direction/ (Accessed 10 April 2026).

18. NHS Business Services Authority (NHSBSA) (2024). NHS Community Pharmacy Independent Prescribing Pathfinder Programme. Available at: https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/dispensing-contractors-information/nhs-community-pharmacy-independent-prescribing-pathfinder-programme [Accessed 17 April 2026].

19. Peng M, et al. (2017) Under-coding of secondary conditions in coded hospital health data: impact of co-existing conditions, death status and number of codes in a record. Health Informatics Journal, 23(3), pp. 178–188. Available at: https://doi.org/10.1177/1460458216647089 (Accessed: 5 May 2026).

20. Queirós P, et al. (2024) Unsupervised algorithms to identify potential under-coding of comorbidities in hospital data. Health Informatics Journal. Available at: https://doi.org/10.1177/18333583221144663 (Accessed: 5 May 2026).

21. Rowe F, et al. (2025) Why NHS hospital co-morbidity research may be wrong. NIHR/PMC. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC12532788/ (Accessed: 5 May 2026).

22. Schommer JC, Gaither CA, Alvarez NA, Lee S, Shaughnessy AM, Arya V, Planas LG, Fadare O and Witry MJ (2022) Pharmacy workplace wellbeing and resilience: themes identified from a hermeneutic phenomenological analysis with future recommendations. Pharmacy 10(6): 158.

23. Tancock, C., et al. (2023) 'Barriers and opportunities for the use of digital tools in medicines optimization across the interfaces of care', *JMIR Human Factors*, 10, e43312.

24. The Pharmacist (2025) Finances and integration a challenge for pharmacies expanding clinical services. Available at: https://www.thepharmacist.co.uk/pharmacy-first/finances-and-integration-a-challenge-for-pharmacies-expanding-clinical-services/ (Accessed 10 April 2026).

25. Thomson, C. and Ibrahim, S. (2024) 'Embedding equality, diversity and inclusion in the pharmacy workforce in England', *International Journal of Pharmacy Practice*, 32(Suppl. 2), pp. ii49–ii50.

26. Tsuyuki, R.T., Osasu, Y., Liu, S. and Tong, J. (2025) 'Uptake and results of the National Health Service England community pharmacy hypertension case-finding service', *Journal of Hypertension*, 43(Suppl. 1), p. e29.

27. UWE Bristol (2025) Asthma Care and Management: Professional/Short Course. Faculty of Health & Applied Sciences, University of the West of England. Available at: https://courses.uwe.ac.uk/UZTRUU203/asthma-care-and-management (Accessed: 5 May 2026).

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