Global Policy Network

Global Medicines Policy Series 2025

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

Health System: United Kingdom

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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

ICS - Integrated Care Systems

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

About Global Policy Network

The Global Policy Network (GPN) is an independent, global policy institute dedicated to promoting evidence-informed dialogue in global health, education, and sustainability. GPN combines research, stakeholder insight, and practical policy analysis to shape thoughtful, actionable conversations around some of today's most complex public policy challenges.

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. With a growing network of international practitioners and policymakers, the organisation works to bridge the gap between policy ideas and implementation, ensuring relevance, equity, and sustainability remain at the heart of systems of change.

About the Series

The GPN Medicine Policy series explores the evolving role of pharmacy in delivering integrated, community-focused care in line with National Health Service (NHS) ambitions. Through a series of closed-door roundtables, forums, and insight reports, this series brings together diverse senior healthcare leaders to identify practical improvements that support the integration and expansion of pharmacy services across the care continuum.

Roundtable Six: A Pharmacy Lens on Cardiovascular-Renal-Metabolic & Obesity – Integrated Neighbourhood Care

This roundtable, hosted on 22nd November 2025 at the Clinical Pharmacy Congress North, in Manchester, England, explored how pharmacy-enabled neighbourhood teams in the United Kingdom (UK) can deliver integrated, patient-centred care; particularly focused on people at risk of cardiovascular, renal, metabolic conditions (CVRM) and obesity, as well as those living with multiple long-term conditions (MLTC). These patients represent a highly vulnerable population, facing the compounding burden of health conditions and multiple medications and require greater support from healthcare professionals. The discussion unpacked pharmacy-enabled neighbourhood teams as a model in which pharmacists are embedded as full clinical partners, with access to shared records, independent prescribing (IP) authority, and diagnostic tools, and with defined roles in risk assessment, medicines optimisation, and patient education, supported by a skilled pharmacy technician workforce. Delegates explored how this model can deliver integrated, patient-centred care for people at risk of CVRM conditions and MLTC, with pharmacy capacity and

data visibility as key enablers. This approach is well-aligned to the broader NHS goal of leveraging Integrated Neighbourhood Teams (INTs) to provide proactive, preventative care for individuals managing complex multi-morbidities and high-risk clinical profiles, as described in the NHS 10-Year Plan (Department of Health and Social Care (DHSC), 2025).

Delegates examined medicines optimisation, standardising protocols for initiation, titration, and deprescribing, and ensuring the right medicines reach the right patients at the right time. It also highlighted digital and data enablers for shared care planning, real-time collaboration, and coordinated care, while considering how national policy and incentives can support or hinder progress.

A population-health perspective underpinned the discussion, strengthening pharmacists' leadership, enhancing pharmacy technicians' roles, and driving improvements in long-term condition management, further in line with the NHS 10-Year Plan.

Acknowledgments

We extend our sincere thanks to everyone who contributed their expertise to this roundtable. Chaired by Ghulam Haydar, National Senior Policy Lead, Pharmacy, NHS England, the session benefited from his leadership and clarity of purpose.

We are especially grateful to our speakers David Edeson (BPharm, MPharm, Associate Director for Medicines Optimisation & Clinical Director for Long Term Conditions, West Yorkshire ICB), Alistair Gray (MRCPharm, BSc (Hons), Dip ClinPharm, Chief Pharmacy Information Officer, NW Regional Digital Pharmacy & Medicines Lead), and Stephen Riley (FRCPharm, MPharm, MSc Health Policy, Deputy Regional Chief Pharmacist – Pharmacy Integration, NHS England Northwest).

We are also grateful to our GPN Fellows, who supported this policy roundtable.

Foreword by Ghulam Haydar, National Senior Policy Lead, Pharmacy, NHS England

It was a great pleasure to contribute to this roundtable as a Pharmacist and National Senior Policy Lead at NHS England. Bringing together colleagues at the Clinical Pharmacy Congress North in Manchester, this session arrived at a defining moment for pharmacy's role in the NHS. People living with long-term and metabolic conditions deserve care that is seamless, proactive, and built around their lives. Achieving this demands that we harness the full potential of digital tools, and that pharmacists step confidently into leadership roles within a multidisciplinary neighbourhood.

The conversations held in that room mattered. They reflected a shared commitment to integrated, patient-centered care and to positioning pharmacy not as a supporting actor, but as a driving force in delivering it. The collective wisdom of colleagues from across pharmacy and healthcare was both inspiring and instructive, and it is that dialogue which this report seeks to capture and carry forward.

Foreword by Ameneh Ghazal Saatchi, Founder and CEO, Global Policy Network

At Global Policy Network, we bring together evidence, frontline insight, and system leadership to shape practical, equitable reform. This roundtable: A Pharmacy Lens on Cardiovascular- Renal- Metabolic & Obesity: Integrated Neighbourhood Care, explores how pharmacy can take a more central role in responding to some of the most complex and fast- growing health challenges affecting communities today.

Cardiovascular, renal, and metabolic disorders and obesity are driving the rising demand across the health system and exposing the need for more integrated, preventative, and person- centered models of care. As one of the most accessible parts of the health and care ecosystem, community pharmacy is uniquely positioned to support earlier intervention, continuity of care, and meaningful patient engagement close to home.

The discussion captured in this report highlights the growing opportunity to embed pharmacy as a fully integrated clinical partner within neighbourhood teams. Participants emphasised several system priorities: strengthening pharmacy's role in multidisciplinary models of care, expanding clinical capacity, improving data connectivity and information flow, and aligning services with population health outcomes.

By harnessing the reach and expertise of pharmacists, we have an opportunity to shift towards proactive, community- anchored care that improves outcomes, reduces inequalities, and eases pressure across the system. This roundtable is an important step in that direction.

Executive Summary

The Global Policy Network UK Medicines Policy Series roundtable six, which took place on November 22, 2025, at the Clinical Pharmacy Congress North, is summarised in this policy report along with its conclusions and suggestions. Senior pharmacy and academic leaders attended the session, "*A Pharmacy Lens on Cardiovascular-Renal-Metabolic & Obesity - Integrated Neighbourhood Care",* reviewing the growing burden of CVRM and obesity-related conditions on the NHS and exploring how pharmacy can play a central role in meeting this challenge. Discussions focused on integrated neighbourhood care models, coordinated and community-based approaches. Bringing together health, social care, and voluntary sectors to deliver personalised support across local populations. The participants also addressed how applying a cardio-metabolic lens to these models can enhance primary care delivery and improve population health outcomes.

Delegates stressed the need for a systems approach to CVRM care, with pharmacy fully embedded in neighbourhood teams. Digital interoperability across care settings, workforce preparedness and IP readiness, operational coherence between policy purpose and frontline delivery, and the difficulty of shifting investment into prevention at the neighbourhood level were among the major barriers to embedding pharmacy in neighbourhood teams.

The recommendations urge the NHS England (NHSE) and the Department of Health and Social Care (DHSC) to accelerate the development of a single patient record and strengthen early CVRM management and multimorbidity pathways. The Integrated Care Boards (ICBs) are called upon to establish neighbourhood-level multidisciplinary teams with pharmacy fully embedded and to implement operational readiness reviews prior to service launch. Finally, pharmacy leadership bodies are encouraged to coordinate structured IP readiness. Collectively, these activities position pharmacy not only as a delivery partner but also as a system-wide contributor to population health, early intervention, and integrated care.

Achieving meaningful CVRM transformation would necessitate strong pharmacy leadership at both the national and ICB levels, with pharmacists strategically entrenched to facilitate digital integration, workforce capabilities, and neighbourhood-based prevention.

This report sets out a series of recommendations for ICBs, NHSE, and the DHSC. These suggestions are organised at all system levels and address the full CVRM continuum: from early prevention and risk identification through to the ongoing management of those already living with CVRM and MLTCs.

1. **NHSE and DHSC Digital and Informatics Leads:**

Invest in early-stage CVRM and MLTC prevention and 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 pharmacists fully integrated.

3. **Pharmacy Leaders, ICB Pharmacy Directors and the Royal College of Pharmacy (Formerly the Royal Pharmaceutical Society):**

Support workforce competence/development, develop professional standards, establish regional pharmacy-led education platforms and a single IP preparedness programme - underpinning commissioning of IP services via community pharmacy.

4. **Community Pharmacy and Primary Care Organisations:**

Improve standards for communicating diagnoses to patients, especially for long-term and multimorbid illnesses. Establish clear protocols for communicating diagnoses, particularly for long-term and multimorbid conditions. Ensure explanations are understandable, culturally sensitive, and supported by written follow-up information.

Assign consistent primary care multidisciplinary 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.

Encourage collaboration among general practitioners, nurses, mental health professionals, pharmacists, and social workers to address the broader needs of patients with long-term conditions. Partner with local organisations to raise awareness of chronic disease management, prevention strategies, and available support services. Offer ongoing training for primary care staff on patient-centred communication, shared decision-making, and multimorbidity management.

Introduce routine screening for mental health challenges, such as anxiety or depression, in patients diagnosed with chronic or multiple illnesses. Implement telehealth consultations, electronic health records, and patient portals to improve communication, follow-up, and access to medical information. Offer accessible educational resources, workshops, and digital tools to help patients understand their conditions and actively manage their health.

Establish feedback mechanisms, including patient surveys and community consultations, to assess communication quality and service effectiveness.

Achieving these objectives will necessitate courageous leadership, system-wide transformation, and cultural shifts throughout the system. For pharmacists 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 is timely and necessary, consolidating key in addressing recommendations from senior pharmacy and academic leaders. Representing the intersection between high-level policy ambitioning and addressing practical challenges within the CVRM and obesity care system. Identifying clear, actionable, system-level priorities that focus on integration, early intervention, and neighbourhood delivery. Themes that have not been comprehensively reviewed 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 2025 General Practice and Neighbourhood Provider contracts collectively set out both a renewed national commitment to neighbourhood-based, prevention-focused care and funding models that can enable this vision. This report provides a focused contribution to current CVRM transformation efforts, translating national intent into operationally relevant actions.

Introduction

Over the past decade, cardiovascular disease (CVD) and related long-term conditions have continued to rise across the United Kingdom (UK). An ageing population, increasing multimorbidity, and widening health inequalities mean that many patients are now present with overlapping CVRM diseases. 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. Sources, including the CVRM Centre and the National Cardiometabolic and Renal Network, demonstrate how CVRM conditions overlap clinically and require integrated care approaches, providing case studies and masterclasses on MLTC management that reflect the UK movement toward joined-up CVRM care (CVRM Centre, 2025; British Journal of Cardiology, 2026) This epidemiological shift has exposed structural limitations within the health system, including fragmented care pathways, inconsistent communication across settings, and missed opportunities for early intervention.

Pharmacists are well-positioned to contribute to cardiovascular risk prevention/management and long-term condition care due to their accessibility, clinical expertise and frequent patient contact.

The case for this contribution is rooted in the significant and growing burden of CVRM disease in the UK: approximately 7.6 million people are living with CVD, 3.5 million with CKD, and an estimated 5 million with diabetes, of which 90% is type 2 diabetes (Fernando, 2024). These conditions are inextricably linked at the epidemiological, pathophysiological and molecular levels. Half of all patients with CKD stages 4–5 have CVD, cardiovascular mortality accounts for 40–50% of all deaths in this group, and one third of adults with diabetes in the UK die from heart or circulatory disease (Fernando, 2024). Shared risk factors, including elevated blood pressure, dysglycaemia, dyslipidaemia, and obesity drive the interconnected progression of all three conditions, meaning that dysfunction in one CVRM organ directly contributes to dysfunction in the others (Fernando, 2024). Siloed, condition-by-condition management therefore fails to reflect the biological reality of how these diseases interact, and there is a clear clinical imperative for healthcare professionals to manage CVRM conditions holistically within multidisciplinary, integrated care pathways (Fernando, 2024). Community pharmacy services have expanded beyond medicines supply to include hypertension case-finding, medicines optimisation, and vaccination delivery (NHS England, 2023). Furthermore, the Community Pharmacy Independent Prescribing Pathfinder Programme further demonstrated this expanding role. It tested a range of clinical models across ICBs, that included cardiovascular services, such as hypertension management, lipid optimisation and atrial fibrillation, thus establishing a practical framework for the future of prescribing-based pharmacy services (NHSBSA, 2024). This aligns with increasingly explicit national policy direction, represented by the Medium Term Planning Framework, which asked ICBs to begin rolling out local prescribing-based services, and the Neighbourhood Health Framework, which reinforces this by positioning community pharmacy as a core partner within integrated neighbourhood teams (NHS England, 2025; DHSC, 2026). The Strategic Commissioning Framework further supports this trajectory by setting out how the ICBs should move toward outcomes-focused, population health-oriented service design (NHS England, 2025). Community pharmacies are often important access points for individuals who have limited engagement with other parts of the health system, and their role in early identification, medicines optimisation across CVRM conditions, and support for lifestyle modification positions them as a natural and necessary component of any neighbourhood team adopting an integrated CVRM approach (Fernando, 2024; NHS England, 2023).

However, expansion of service scope has not consistently been translated into stronger system integration. The contribution of community pharmacy to cardiovascular prevention and multimorbidity care remains constrained by system design, workforce readiness, and data fragmentation.

National policy has increasingly emphasised integrated, neighbourhood-based approaches to care delivery (NHS England, 2025). The Neighbourhood Health Framework (Department of Health and Social Care, 2026) sets out the government's defining vision for a neighbourhood health service, establishing the structures,

governance models, common outcome metrics, and financial incentives required to support multidisciplinary neighbourhood teams working with defined populations. It explicitly positions the "left shift" toward prevention, early detection, and MLTC management as central to neighbourhood care reform, and provides the policy architecture within which community pharmacy integration must be understood (Department of Health and Social Care, 2026). The NHS Long-Term Plan and subsequent operational planning guidance prioritise prevention, strengthened primary and community care, and multidisciplinary neighbourhood teams responsible for defined populations (NHS England, 2023; NHS England, 2025; University of Manchester Policy Blog, 2025). The 2025/26 NHS planning guidance further reinforces early intervention, digital enablement, and population health management as central to system reform (NHS England, 2025). Cardiovascular conditions are identified as a priority area in the guidance, alongside broader commitments to address conditions that contribute to avoidable hospital admissions and long-term health expenditure, including renal disease. At the local level, the Telford & Wrekin ICB CVRM Strategy 2025–2030 demonstrates how this national ambition can be operationalised, offering a model of integrated CVRM care that aligns with the NHS Long-Term Plan, the Neighbourhood Health Programme, Core20PLUS5, and digital innovation priorities. Incorporating neighbourhood team structures, early diagnosis pathways, workforce models, governance frameworks, and population health dashboards, the strategy explicitly addresses pharmacy-relevant priorities, including hypertension case-finding, early CKD detection, diabetes optimisation, and a sustained focus on health inequalities (Telford & Wrekin ICB, 2025) This whole-systems orientation is further reinforced by guidance from the Office for Health Inequalities and Disparities (OHID), which advocates for defined geographic community approaches to reducing health inequalities, recognising that coordinated action across NHS, local government and community partners is essential to addressing the structural drivers of poor cardiovascular outcomes (NHS England, 2019). The Neighbourhood Health Framework reinforces this position, emphasising that multidisciplinary collaboration across organisational boundaries, including with community pharmacy, is essential to delivering neighbourhood health outcomes equitably (Department of Health and Social Care, 2026). The pharmacy's reach into deprived and underserved communities positions it as a natural partner within such place-based frameworks.

Despite this guidance and policy direction, implementation remains inconsistent. Key barriers to implementation, including data fragmentation, diagnostic gaps, and uneven workforce readiness, are explored in the insights section that follows (Edwards and Lewis, 2024; NICE, 2021). Workforce pressures further compound these challenges, including variable access to training and uneven readiness for expanded clinical roles such as independent prescribing (NHS England, 2025).

The shift toward neighbourhood care has also introduced governance and accountability challenges. ICBs are tasked with delivering population health outcomes across organisational boundaries, yet practical mechanisms for joint decision-making

and service coordination remain variably developed. The Neighbourhood Health Framework directly addresses this gap, providing a common governance architecture and accountability framework intended to support coordinated delivery across primary, community and pharmacy settings (Department of Health and Social Care, 2026).

Against this backdrop, an implementation deficit persists between national policy ambition and local delivery. This roundtable was convened to examine this deficit through a pharmacy lens, focusing on CVRM, multimorbidity, and neighbourhood care. Bringing together sixteen senior leaders from pharmacy, commissioning, digital health and policy, the session aimed to identify pragmatic enablers necessary to translate national strategy into effective local delivery.

This roundtable is distinct from earlier integration discussions because it was pharmacy-led, system-focused, and operationally grounded. Rather than reiterating policy ambition, it sought to identify concrete governance, workforce and digital mechanisms required to embed pharmacy within cardiovascular and neighbourhood care models. 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).

Key Insights

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

Delegates emphasised the importance of a national, interoperable single patient record, with read/write access for pharmacists to promote optimal CVRM and community care:

"If there are any common fields in any health system, they need to be interoperable, so it only gets recorded once, or it only gets updated once for whichever system you're in."

Current digital systems in GP practice, community pharmacy and NHS trusts do not always share diagnoses, test results, or therapy changes. Hospital-initiated medication or diagnostic updates do not always return to general practice systems, and many persons with chronic kidney disease (CKD) are unaware of their diagnosis due to inconsistencies in communication between treatment 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 Comprehensive, Not Single-Disease Pathways

Delegates expressed concern that the health system remains organised around individual conditions, despite most patients living with multiple, interacting cardiovascular, renal and metabolic risks. Participants noted that patients are often required to repeat their medical history at each point of care, while multimorbidity frequently spans cardiovascular, renal, metabolic, and mental health domains. As a result, individuals move between cardiology, nephrology, diabetes services, general practice and community care without a single, integrated care plan.

"*What patients say is they are just going to appointments, repeating the same story over and over again.*"

This fragmentation was described as generating duplication, inefficiency, and avoidable harm, with missed opportunities for early intervention when conditions are assessed and managed in isolation. Delegates highlighted that disease-specific pathways fail to reflect the lived complexity of patients with multimorbidity and limit effective prevention and risk management.

A related concern is the continued use of single-condition hospital coding in clinical records. Where a patient's episode is coded against one primary diagnosis, 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).

Participants called for a shift towards integrated care pathways supported by shared assessment approaches. These were described as including common assessment templates, joint multidisciplinary reviews and structured case conferences across neighbourhood teams, enabling holistic care planning and coordinated follow-up. Such models were seen as essential to improving continuity, reducing duplication, and supporting proactive CVRM management at neighbourhood level.

3. Workforce Education and IP Readiness Vary Across Settings

Pharmacists reported wide variation in capability, confidence and access to training, particularly in relation to managing complex, multimorbid patients in primary care. National workforce evidence indicates that the expansion of clinical pharmacy roles has not been matched by consistent preparation, supervision and system support, leaving some pharmacists underprepared for the complexity associated with CVRM care (Meilianti et al., 2024).

"*We are going to be the first professionals, other than medics, who will qualify with the ability to prescribe independently, which is a momentous thing for our profession. But there's a huge element there, how we do that wraparound support, and how we utilise that effectively and proactively.*"

Evidence from the Independent Prescribing Pathfinder Evaluation - Final Report (2025) shows that IP capability depends on more than qualification alone. The evaluation identifies protected learning time, structured clinical supervision, mentoring, and supervised experiential learning within multidisciplinary teams as critical enablers of prescribing readiness. The report further highlights that inconsistent access to these supports negatively affects pharmacist confidence, increases perceived clinical risk, and limits safe integration into primary care teams.

Delegates identified the need for structured, regionally coordinated training frameworks that embed formal IP readiness pathways. This aligns with national policy evidence emphasising that pharmacist prescribers require clear governance arrangements, supervision models, and sustained workforce investment to support safe and effective practice (NHS Confederation, 2023; Schommer et al., 2022). Embedding these frameworks was seen as essential to supporting pharmacists working in complex CVRM roles, strengthening patient safety, and enabling effective participation in integrated neighbourhood care teams (Fuller, 2022).

Beyond prescribing readiness, delegates noted a gap in formalised education on the clinical fundamentals of CVRM. Structured postgraduate frameworks already exist for comparable long-term conditions: healthcare professionals can access accredited modules and programmes in diabetes care through institutions such as Birmingham City University, King's College London, and the University of Leicester (Diabetes UK, 2025), and equivalent short courses and credit-bearing modules in asthma and COPD management through universities including UWE Bristol and the University of Sunderland (UWE Bristol, 2025; University of Sunderland, n.d.). No equivalent infrastructure currently exists for CVRM as an integrated clinical area. Establishing accredited short courses, diploma programmes, or postgraduate modules focused specifically on CVRM would provide healthcare professionals with formal recognition of learning, strengthen clinical confidence, and support more consistent practice standards across ICBs.

4. Operational Barriers Undermine National Policy Intent

Delegates emphasised that ICBs must establish clear operational readiness checks prior to service implementation.

"*We launched a service without considering how people talk to each other and how it was going to work operationally. That will always stick with me.*"

A recurring pattern was described in which national service intentions did not align with operational realities at the local level. Examples included inconsistent pathway

design, unclear referral mechanisms, and workload shifts that were not fully anticipated during policy development.

The experience of Pharmacy First was frequently referenced as an illustration of these challenges. An NHS advanced service launched in January 2024, enabling community pharmacists to complete full episodes of care for seven common conditions without a GP appointment. Delegates noted that variations in pathway interpretation, referral criteria and communication between general practice and community pharmacy led to confusion and inefficiency during initial implementation. A perception of rushed rollout and insufficient operational alignment across primary care settings was identified as a persistent system weakness. Delegates suggested that formal operational readiness reviews, undertaken jointly with delivery teams, could have mitigated these issues by clarifying roles, referral routes and capacity assumptions in advance.

Workforce education and IP readiness were identified as closely linked to operational success. Delegates highlighted that insufficient preparation, supervision/mentoring and support for prescribing roles can create potential risks for patient safety and undermine professional confidence in clinical decision-making. Delegates stressed that pharmacists delivering prescribing roles require structured training, clinical mentorship, and clear governance arrangements to practice safely within multidisciplinary teams.

In addition, delegates raised concerns about hypertension services, noting that pathway design and follow-up requirements had generated unintended workload pressures in GP practice services. Particularly relevant within the context of the NHS Community Pharmacy Hypertension Case-Finding Service. Commissioned as an advanced service since October 2021 and commonly known as the NHS Blood Pressure Check Service. It enables community pharmacists to identify adults with potential undiagnosed hyperetension. Undertaking ambulatory blood pressure monitoring and formally referring to general practice for diagnosis and management. Despite a commissioned and funded NHS community pharmacy service, the uptake has remained lower-than-expected, therefore is a greater risk of people with un-diagnosed hypertension developing CVD related complications. Leading to an increased workload for GP Practice and wider healthcare systems in the longer term. (Tsuyuki, et al., 2025). This was cited as further evidence that service design must account for operational capacity and workforce readiness alongside clinical ambition.

5. Left Shift Requires Investment, Not Reallocation

Delegates underlined the urgent need to transition from activity-based funding models to system-level investment that is associated with patient outcomes. Current funding mechanisms were seen as promoting fragmented care, with expensive procedures such as dialysis becoming increasingly unsustainable. Participants

emphasised that funding cannot simply be shifted from acute to primary care without disrupting existing services, and that prevention-focused spending must be increased rather than diverted.

The discussion followed the NHS 10 Year Health Plan's shift to prevention, early intervention, and population health management. Delegates highlighted that making this transformation will necessitate financial structures that reflect the long-term importance of prevention for patients and the larger health and care sector. National risk stratification and prioritisation frameworks were highlighted as critical enablers, allowing systems to focus investment on persons with the highest cardiovascular and renal risk and to facilitate more efficient, outcomes-driven care across neighbourhood routes.

6. Patient Understanding and Engagement Are Critically Weak

Delegates' considerations were consistent with the results of the National Institute for Health and Care Excellence's (NICE) 2021 report. Determining that a significant proportion of patients with CKD are unaware of their diagnosis or its clinical consequences. This lack of awareness leads to delayed intervention and poor health outcomes. To address this, delegates called for broader access to early diagnostic testing, targeting public health campaigns to help patients recognise early warning signs. Underpinned by greater investment in healthcare professional capacity to deliver timely testing and follow-up.

Pharmacy professionals recognised the emotional and ethical challenges of communicating challenging diagnoses, which is consistent with findings that highlight the stress and burnout associated with delivering complex clinical information without proper support (Schommer et al., 2022). One delegate raised a pressing concern about what this means for the pharmacy workforce going forward:

"*I am worried about primary care pharmacists. They will need to tell patients they have CKD if their GPs don't. We're going to deal with patients who don't know their diagnosis and pharmacists who don't know how to tell them. I wonder how we're going to overcome that.*"

A possible solution was proposed by Thomson and Ibrahim (2024), who emphasise the need for improved communication training for healthcare professionals, combined with patient engagement strategies to equip healthcare staff to manage delicate conversations effectively.

Furthermore, as mentioned in Edwards and Lewis (2024), patients frequently receive fragmented or incomplete information, limiting efforts to build trust and understanding across care settings. Community Pharmacy England (2025) found a critical gap in community-level patient education frameworks, calling for systematic

methods for patient education and shared decision-making tools that support self-management.

Beyond reactive care, greater emphasis must be placed on preventative engagement with communities at higher risk of cardiovascular and renal disease, including Black and South Asian populations, who face disproportionately higher rates of hypertension and CKD (Chaturvedi et al., 2024). Culturally tailored education and proactive outreach, rather than waiting for patients to present with established diagnoses, are essential to reducing health inequalities and enabling earlier, self-directed risk reduction.

Improving communication training for pharmacy teams, along with developing accessible, locally relevant educational tools, is essential to improving patient awareness, engagement, and results in cardiovascular and renal care.

7. Neighbourhood Integration Depends on Relationships and Multidisciplinary Team (MDT) Learning

Delegates highlighted effective neighbourhood integration models, such as heart failure academies and established neighbourhood teams, where structured multidisciplinary learning has been shown to improve care coordination and patient outcomes.

"*We got the entire multidisciplinary team learning together, hosted at each table by one of the specialists. The conversations stimulated were amazing: people understanding each other's roles and how they could overcome their locality issues. You really enable those conversations when you're all in the room together.*"

Evidence from integrated cardiovascular and long-term condition programmes demonstrates that shared learning environments support consistent clinical understanding, improve adherence to pathways, and strengthen multidisciplinary decision-making across primary and community care (Edwards & Lewis, 2024).

These successful models share common enabling features. Trust between professionals, regular communication, and protected time for MDT working were identified as essential components of effective neighbourhood care. The literature consistently shows that without protected MDT time and clear collaborative structures, neighbourhood integration initiatives struggle to sustain impact (Homayounifar et al., 2025).

Delegates further emphasised the importance of operational governance and formal engagement frameworks. Studies examining integrated neighbourhood teams highlight that clear accountability, defined roles, and funded coordination mechanisms are critical to enabling collaboration between community pharmacy, general practice, and ICBs (Edwards & Lewis, 2024). Evidence from heart failure

programmes and initiatives based on Primary Care Network (PCN) illustrates how investment in governance structures and multidisciplinary education can support service sustainability, improve professional collaboration, and reduce fragmentation across cardiovascular care pathways (NHS England, 2023).

Community pharmacy is uniquely positioned to contribute to neighbourhood integration across CVRM care pathways. The NHS Community Pharmacy Hypertension Case-Finding Service provides a strong and established evidence base for pharmacy-led case-finding and medicines optimisation within primary care. More broadly, community pharmacy's accessibility makes it an effective setting for opportunistic screening, medicines optimisation, behavioural change conversations, and the management of multimorbidity and polypharmacy. All of which are central to CVRM care. This is particularly significant given the epidemiological evidence on CVRM clustering: CVD, CKD, and type 2 diabetes are pathophysiologically interconnected, with high rates of co-occurrence that place considerable demand on integrated care systems (Practice Nurse, 2024). Embedding community pharmacy within integrated neighbourhood teams and ICS structures represents a practical and evidence-based opportunity to strengthen CVRM care, extend early intervention beyond general practice, and reduce fragmentation across pathways.

Recommendations

1. NHSE and DHSC: Multimorbidity and Integrated Pathways

The Issue

Current cardiovascular and renal pathways remain structured around single-disease models, despite multimorbidity being the dominant pattern of illness. Patients with overlapping CVRM risks experience fragmented care, repeated history-taking, and poor continuity. Early intervention opportunities are frequently missed. Albuminuria and pharmacy-recorded blood pressure data are not consistently integrated into shared clinical systems, limiting proactive risk management. Current hospital coding practices compound this problem: where episodes are coded against a single primary diagnosis, patients' co-occurring CVRM conditions are frequently not captured, undermining risk stratification and skewing commissioning data at ICB level (Rowe et al., 2025; Peng et al., 2017; Queirós et al., 2024).

Implications for Practice & Policy

NHSE and DHSC should:

- 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 multimorbid patients at neighbourhood level.
- Promote unified care plans with coordinated follow-up across primary care, community care and specialist services.
- Review and reform hospital coding standards to require systematic recording of multimorbidity, ensuring that co-occurring CVRM conditions are captured alongside a primary diagnosis.

Next Steps

- Explicitly incorporate the needs of patients with multimorbidity at the point of design within the national service specifications.
- Align digital strategy with neighbourhood integration.
- Incentivising integrated risk management rather than condition-specific activity targets and payment per item of service.
- Work with NHS Digital and coding leads to develop multimorbidity-sensitive coding frameworks, and audit existing records to identify patients with unrecognised CVRM co-morbidities who may be receiving single-disease care.

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

The Issue

Delegates identified that digital systems across the NHS do not currently work well together. Important information is often missing or delayed.

For example:

- Hospital diagnoses (such as CKD) do not always appear in general practitioners' (GPs') records.
- Medication changes made in hospitals are not always visible to community pharmacy.
- For newly identified hypertension cases, blood pressure readings are communicated electronically to general practice via the NHS Community Pharmacy Hypertension Case-Finding Service; no such requirement exists for patients with an existing diagnosis, where information-sharing depends on individual pharmacy practice.
- Data from wearables and health apps is rarely used in a structured way.

National policy recognises that interoperable systems are essential for safe, integrated care (NHS England, 2023–2025). Programmes such as the NHS Federated Data Platform and shared care record initiatives aim to improve this, but pharmacy integration remains inconsistent. Without reliable shared data, patient safety, continuity of care, and workforce confidence are affected.

Implications for Practice & Policy

NHSE and Digital Leads should:

- Accelerate the implementation of interoperable shared care records with read/write access to community pharmacy.
- Ensure community pharmacy collected service 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.

3. ICB Pharmacy Directors and the Royal College of Pharmacy, Formerly the Royal Pharmaceutical Society) Workforce Development, Education and Independent Prescribing

The Issue

Delegates described a community pharmacy that is motivated and skilled but not consistently supported for complex primary care roles. IP reform was welcomed. However, evidence from the Independent Prescribing Pathfinder evaluation (NHS England, 2025) shows that qualification alone is not enough.

Pharmacists need:

- Protected learning time.
- Clinical supervision.
- Mentoring.
- Practical experience in multidisciplinary teams.

Without this support, prescribing confidence may fall, particularly after difficult clinical cases. Delegates also highlighted the emotional and professional burden of managing complex diagnoses and communicating sensitive information to patients.

Implications for Practice & Policy

ICBs should:

- 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.

RPS and NHSE should:

- Develop national frameworks for mentoring and wraparound support.
- Standardise supervision expectations across regions.
- Support workforce wellbeing alongside clinical development.
- Commission the development of accredited CVRM education pathways in partnership with universities.

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

The Issue

Delegates recognised the importance of shifting towards prevention and community care. However, they stressed that prevention cannot succeed without new investment. Acute services such as dialysis already face rising costs. Simply moving money from hospitals to primary care could risk destabilising services. National guidance increasingly supports prevention and neighbourhood models (NHS England operational planning guidance 2025/2026), but local systems need clear funding mechanisms to deliver this shift safely.

Implications for Practice & Policy

DHSC and NHSE should:

- 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.

ICBs should:

- Consider pooled prevention budgets or neighbourhood innovation funds.
- Target investment toward patients at highest cardiovascular and renal risk.
- Ensure NICE guideline implementation is properly resourced.

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

The Issue

Delegates gave examples where policy intentions did not match day-to-day practice. Pharmacy First was cited as a case where unclear referral routes and system readiness issues created frustration. Hypertension pathways were also described as creating unintended workload pressures when single readings triggered complex follow-up processes. Delegates agreed that services must be designed with operational realities in mind.

Implications for Practice & Policy

ICBs and Providers should:

- 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.

Persistent Challenges and Strategic Priorities in Pharmacy

Workforce Challenges

Published research consistently reports workforce shortages, retention concerns, and workload pressures across the pharmacy sector. A systematic analysis of pharmacy workforce stability found that expanded clinical responsibilities, rising workload, and shifting professional expectations negatively affected job satisfaction and retention (Homayounifar et al., 2025).

A narrative review examining global pharmacy workforce concerns identified recurring challenges, including working conditions, regulatory complexity, professional recognition, and competency gaps, as ongoing threats to workforce sustainability (Meilianti et al., 2024).

Workplace wellbeing has also emerged as a significant concern. A qualitative study exploring resilience in community pharmacy found that business-driven performance targets, limited professional autonomy, and increasing service demands were associated with stress and burnout (Schommer et al., 2022).

In England, research on equity, diversity and inclusion highlighted differences in professional experience by gender and ethnicity, alongside national initiatives aimed at promoting inclusive workforce practices (Thomson and Ibrahim, 2024).

Implications for Cardiovascular Risk Management

Workforce instability directly affects continuity of care, relationship-based risk management, and long-term follow-up for patients with multimorbidity. Cardiovascular prevention relies on consistent medication optimisation, monitoring, and patient engagement. High turnover, burnout and limited protected learning time can undermine safe prescribing expansion and reduce the effectiveness of neighbourhood-based CVRM delivery.

Operational and Financial Pressures

Multiple sources highlight financial constraints associated with the expansion of clinical pharmacy services. Ann independent economic analysis of community pharmacy service delivery in England noted ongoing funding pressures as pharmacies extended services such as contraception provision, blood pressure monitoring and structured medicines support (The Pharmacist, 2025).

Digital and operational barriers further compound these pressures. National policy analysis indicates that community pharmacy digital systems remain insufficiently integrated with general practice and secondary care systems. Limited interoperability continues to affect referral pathways, clinical data sharing, and service coordination (NHS England, n.d.)

Financial constraints and digital immaturity are closely linked. Limited investment reduces the ability of pharmacies to upgrade IT systems, train staff in digital workflows, or implement interoperable solutions. In turn, poor digital connectivity restricts the safe expansion of clinical roles and weakens multidisciplinary cardiovascular care delivery.

Expansion of Scope of Practice

Policy documents published since 2022 confirm a formal expansion in pharmacists' scope of practice, particularly through reforms supporting IP from the point of

registration. These reforms reflect recognition of pharmacists' potential contribution to primary care and long-term condition management (Counihan et al., 2025).

However, policy guidance also emphasises that the scope of expansion must be matched with workforce infrastructure, governance frameworks, and training capacity. Independent prescribing requires structured supervision, mentoring, protected learning time, and clear accountability pathways.

Infrastructure requirements are directly linked to safe CVRM delivery. Prescribing for hypertension, heart failure, or CKD involves complex decision-making, multimorbidity considerations, and risk stratification. Without robust clinical supervision and system support, expanded prescribing responsibilities may increase professional risk and reduce confidence among early-career prescribers.

Effective scope of expansion, therefore, depends not only on regulatory reform, but also on sustained investment in mentorship models, multidisciplinary integration, and digital record access to support safe and coordinated cardiovascular care.

Strengthening the Integration of Pharmacy

Integration into Primary Care and Health Systems

Peer-reviewed literature consistently shows that community pharmacies remain only partially integrated into wider health systems, despite being located within primary care settings. A 2022 review found that community pharmacies often operate in parallel to other healthcare providers rather than as fully embedded members of primary healthcare systems (Integration of Community Pharmacy in Primary Health Care, 2022). The same review highlighted conceptual ambiguity across policy and academic literature. (Piquer-Martinez et al., 2022).

This ambiguity has practical consequences. Without clear definitions or shared expectations, local systems may develop inconsistent service models, unclear referral pathways, and poorly defined clinical accountability. The result is role confusion, duplication of work and under-utilisation of pharmacy expertise, particularly in complex areas such as cardiovascular risk management.

For the purposes of this report, GPN defines *integration* as the purposeful embedding of community pharmacy as an equal partner within primary care pathways, underpinned by shared governance, clearly defined clinical accountability, coordinated referral pathways, and interoperable access to patient data across multidisciplinary teams.

More recently, a 2025 scoping review identified multiple barriers to pharmacy integration, including governance limitations, limited inter-sector trust, workforce shortages, restricted access to patient records, inadequate funding mechanisms and

infrastructure gaps. These structural barriers reinforce separation rather than system-wide collaboration and constrain the pharmacy's contribution to neighbourhood-based cardiovascular prevention.

Independent Prescribing and Service Integration

Studies published between 2022 and 2024 describe the growing integration of pharmacist independent prescribers into general practice and PCNs to support direct patient care and reduce GP workload pressures. This shift reflects recognition of pharmacists' clinical capability in managing long-term conditions, including hypertension and cardiometabolic risk.

However, integration models remain highly variable. A 2025 scoping review of community pharmacist IP found substantial differences in governance arrangements, scope of practice, supervision models, and collaboration with other healthcare professionals (Karim, 2025).

This variation creates inequity in patient access, inconsistency in service quality, and uncertainty regarding clinical responsibility. In cardiovascular care, where prescribing decisions require longitudinal monitoring and multidisciplinary coordination, inconsistent integration models may weaken continuity and risk management.

Policy Implication

National or regional frameworks should define minimum service integration standards for pharmacist IP models, including governance, supervision, mentorship, patient record read/write access, and multidisciplinary communication requirements. Standardisation would support safe expansion while preserving local flexibility.

Interprofessional Collaboration

Evidence suggests that structured interprofessional collaboration between pharmacists and other community-based professionals remains underdeveloped. An evaluation of collaborative care models found limited documented frameworks supporting sustained pharmacist–community health worker partnerships, despite policy emphasis on multidisciplinary neighbourhood teams (Alhassan et al., 2025).

Barriers include professional silos, limited shared digital infrastructure, and unclear accountability structures. These challenges restrict coordinated cardiovascular prevention, particularly for patients with multimorbidity who require integrated medication management, lifestyle intervention, and monitoring.

However, emerging examples offer grounds for optimism. Cardiometabolic pharmacist-led models within PCNs demonstrate improved medicines optimisation, structured hypertension management and enhanced multidisciplinary case discussions in some regions (Coleman et al., 2026; Prescqipp, 2025). These models

illustrate that where governance, digital access, and defined roles are aligned, pharmacist integration can strengthen cardiovascular outcomes and reduce system burden. Scaling such examples requires clearer national guidance, shared digital infrastructure, and investment in relationship-based multidisciplinary working.

Policy Changes: What Do We Stop and Start Doing?

Stopping Existing Policy Approaches

Short-term Commissioning and Siloed Deployment
Published policy analyses report that short-term pilots and time-limited funding models are a recurring feature of community pharmacy service commissioning. Despite demonstrated service delivery benefits for patient care, pilot schemes frequently conclude without long-term adoption — creating workforce instability and breaking continuity of care (The Pharmacist, 2025; House of Commons Health and Social Care Committee, 2024). This approach must stop because it treats pharmacy integration as a series of short-lived experiments rather than a settled part of the health system.

Alongside this, pharmacists continue to be deployed within sector-specific silos, with limited coordination across GP Practice, secondary care, and community pharmacy. This fragmentation leads to duplicated effort, unclear responsibilities, and restricted interprofessional collaboration, and must be actively dismantled rather than managed around (Piquer-Martinez et al., 2022; Faraco et al., 2020).

Fragmented Digital and Information Systems
Community Pharmacy systems currently lack interoperability with GP Practice system and hospital patient records, meaning clinicians frequently duplicate documentation and lack access to complete clinical histories. Commissioning and deploying community pharmacy services against the backdrop of these fragmented systems embeds the problem further. The practice of accepting non-interoperable systems as a baseline condition must stop (Baird et al., 2023; Tancock et al., 2023).

Starting New Policy Approaches

Long-term, Pathway-Embedded Commissioning
In place of time-limited pilots, NHS policy must shift to commissioning community pharmacy services as permanent components of structured care pathways. This means establishing pharmacists including independent prescribers within general practice

and multidisciplinary teams under shared governance frameworks, with defined roles and long-term funding commitments (Alshehri et al., 2023; Karim, 2025).

Formal Infrastructure for Expanded Scope of Practice

Expanding pharmacists' scope, including independent prescribing qualifications, requires more than policy intent. Specific infrastructure must now be built: training capacity, supervision arrangements, governance frameworks, and workforce support systems. Without this, role expansion remains aspirational rather than operational (Counihan et al., 2025).

Mandating Interoperability of Patient Records

Shared or single patient records must become a policy requirement, not a development aspiration. Access to medicines information, clinical histories, and discharge summaries across care settings is a prerequisite for integrated pharmacy services, not a secondary benefit (Tancock et al., 2023).

Formalised Interprofessional Collaboration

Structured collaboration between pharmacists and other healthcare professionals must be formalised through defined frameworks, not left to emerge informally. This includes embedding interprofessional training into workforce education to support coordinated practice across sectors (Alhassan et al., 2025; Thomson and Ibrahim, 2024).

Overall, these shifts represent a move away from time-bound, transactional models toward embedded, system-owned transformation: commissioning that supports long-term adoption, pharmacy roles integrated across settings, interoperable records, and clear shared accountability within multidisciplinary teams.

Delegates of Roundtable Six

The findings and recommendations presented in this report draw on discussions held at the sixth UK Medicines Policy Series Roundtable of the Global Policy Network, which took place on 22 November 2025. Sixteen senior leaders from across pharmacy and academia contributed their expertise to inform this work.

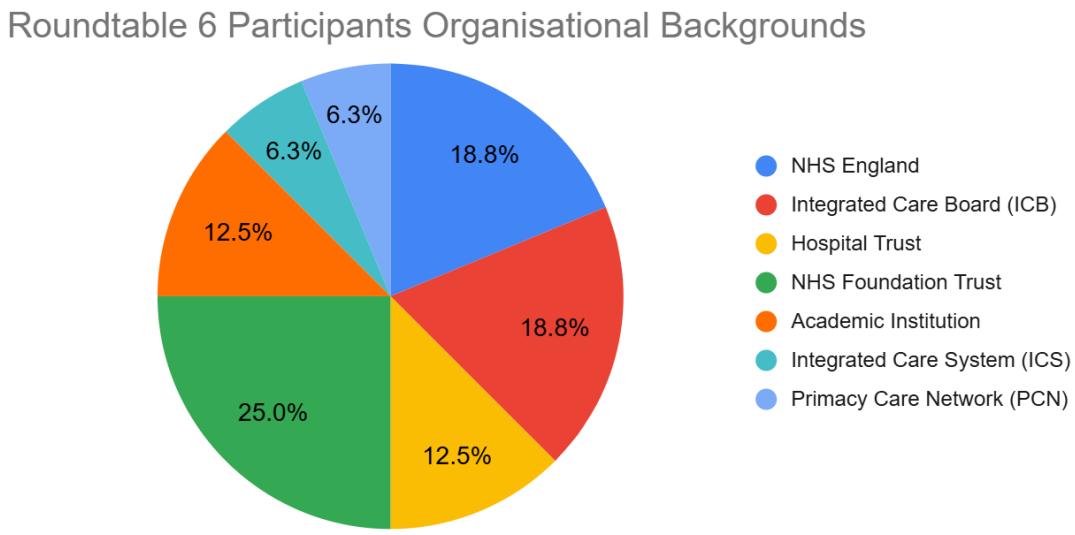

Figure 1. Delegates' organisational backgrounds.

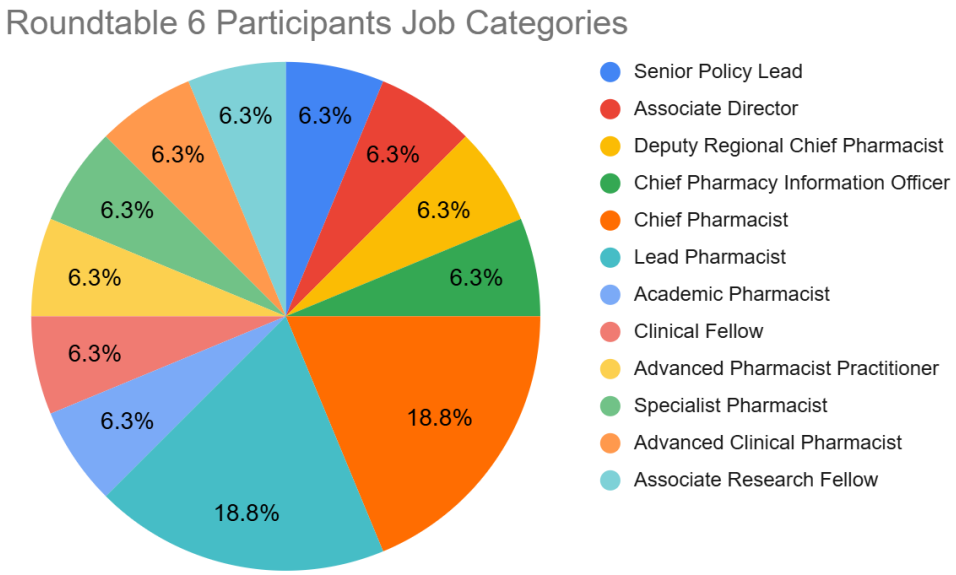

Figure 2. Delegates' job categories.

Participants List

1. Ghulam Haydar: National Senior Policy Lead, Pharmacy, NHS England
2. David Edeson: Associate Director for Medicines Optimisation & Clinical Director for Long Term Condition, West Yorkshire ICB
3. Stephen Riley: Deputy Regional Chief Pharmacist, NHS England Northwest
4. Alistair Gray: MRPharmS, BSc (Hons), DipClinPharm, Chief Pharmacy Information Officer, NW Regional Digital Pharmacy & Medicines Lead
5. Nasrin Khan: Head of Clinical Services and Chief Pharmacist, GPS Helathcare
6. Minesh Parbat: Chief Pharmaceutical Officer, NHS Shropshire
7. Samria Osman: Academic Pharmacist, University of Birmingham
8. Amna Khan-Patel: Chief Pharmaceutical Officer's Clinical Fellow, NHS England
9. Anisa Islam: Lead Pharmacist for Formulary & High-Cost Drugs, Walsall Manor Hospital, Walsall Healthcare Trust
10. Min Na Eii: Advanced Pharmacist Practitioner, South Tyneside and Sunderland NHS Foundation Trust
11. Mehvosh Akhtar: Specialist Renal and Medical Education Pharmacist, MFT NHS Foundation Trust
12. Kenny Li: Chief Pharmacist, NHS Greater Manchester
13. Anneka Wan: Lead Pharmacist - Endocrine and Diabetes, Blackpool Hospital
14. Stacey Davidson: Strategic lead for Partnerships and Innovation, Viaduct Care CIC
15. Shannon Nickson: Advanced Clinical Pharmacist - Heart Failure Education and Researcher, Leeds Teaching Hospitals NHS Trust
16. Raman Sharma: Lead Pharmacist and Associate Research Fellow, Undercliffe Health Centre and University of Huddersfield

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