Global Policy Network

Global Medicines Policy Series 2025

Scaling Independent Prescribing in Community Pharmacy: A Policy Brief

Health System: United Kingdom

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The Potential of Scaling Independent Prescribing in Community Pharmacy

A Policy Brief following the Roundtable convened on 1 July 2025
Health System: United Kingdom

Executive Summary

Independent Prescribing (IP) by pharmacists is now central to delivering the National Health Service (NHS) 10-Year Plan's three core shifts: from treatment to prevention, from acute to community-based care, and from analogue to digital services. From September 2026, all newly registered pharmacists in England will qualify as independent prescribers, making pharmacy the second profession after physicians to prescribe independently from the point of registration. This creates a rapidly expanding IP-enabled workforce that is integral to delivering timely, medicine-focused care in community settings, improving patient outcomes, strengthening system efficiency and sustaining the primary care workforce. However, structural, commissioning, workforce and cultural barriers are preventing this capability from being fully utilised.

Delegates emphasised that pharmacists, and community pharmacy in particular, must not remain on the margins of strategy and commissioning. Pharmacists should be embedded within the design, resourcing and governance of primary care and neighbourhood services, rather than consulted only at the point of implementation. In parallel, IP in community pharmacy must become a mainstream, funded component of primary care to support pharmacist's practice of their prescribed skills. Without appropriate roles, time, supervision and digital access, many independent prescribers feel "lost" and unable to apply the skills they have trained for – a missed opportunity for patients, the health system and the pharmacy workforce.

Roundtable participants identified five core barriers to scaling IP:

1. Commissioning gaps and lack of funded roles mean many trained prescribers cannot use their skills in practice.

2. Insufficient Designated Prescribing Practitioner (DPP) capacity and unfunded supervision create training bottlenecks.

3. Pharmacy technician shortages keep pharmacists tied to dispensing and administrative activities rather than clinical care.

4. Fragmented integration with general practice and primary care including limited access to shared patient records hinders safe, joined-up prescribing.

5. Persistent cultural and perceptual barriers undermine trust in pharmacists as prescribers and limit their visibility in national strategy and workforce plans.

International experience from Scotland, New Zealand, Australia and Canada demonstrates that these barriers are solvable when IP is backed by ring-fenced funding, structured supervision, clear role definition, investment in pharmacy technicians and interoperable digital systems.

This brief sets out a set of practical actions for NHS England, the Department of Health and Social Care, Integrated Care Boards (ICBs), Primary Care Networks (PCNs), professional bodies and educational institutions. These include:

- Establishing a national commissioning framework for community pharmacy IP, with recurrent, outcomes-based funding.
- Building a national DPP and supervision infrastructure, including regional supervision hubs and a digital supervision platform.
- Investing in the pharmacy technician workforce to release pharmacist time for prescribing and clinical care.
- Embedding community pharmacy and IP within primary care pathways, Integrated Care Systems (ICS) governance and workforce plans.
- Designing flexible, outcomes-focused service specifications that avoid overly narrow, pathway-specific commissioning.
- Implementing a coordinated trust-building strategy that publishes IP outcomes and actively addresses professional and public misconceptions.

If implemented, these reforms would move IP from the status of a promising pilot or qualification to a core feature of community-based primary care. This will be essential if the NHS is to meet rising demand, protect access, and deliver on the ambitions of the NHS 10-Year Plan while realising benefits for patients, the wider health system and the pharmacy workforce.

Introduction

Over the last decade, community pharmacy in the United Kingdom (UK) has moved from a predominantly dispensing role to an increasingly clinical, patient-facing function. Services such as the Community Pharmacist Consultation Service and Pharmacy First have positioned pharmacists as first-contact professionals for minor illness, urgent medicines supply and aspects of long-term condition management, diverting activity from general practice and urgent care.

Despite this progress, full utilisation of the community pharmacy workforce is constrained by workforce shortages, fragmented commissioning, limited access to

supervision and uneven digital integration. At the same time, the NHS 10-Year Plan sets out a clear direction of travel: care closer to home, stronger neighbourhood teams and digitally enabled, preventive services. Pharmacists, as independent prescribers from the point of registration, are central to delivering this shift, not a peripheral add-on.

IP is a key enabler of this transformation. It allows suitably trained pharmacists to assess, diagnose within their scope of competence, prescribe and review medicines in community settings. International evidence shows that pharmacist prescribing improves access, supports chronic disease management, increases system resilience and can improve workforce satisfaction when appropriately regulated and supported.

The Global Policy Network's second medicines roundtable was convened to examine how IP can be embedded at scale in community pharmacy in England, identify the main barriers and distil practical recommendations for policy and implementation. Delegates were clear that success will be judged on three fronts: better outcomes and experience for patients, a more efficient and resilient health system, and a supported pharmacy workforce that is able to use its skills in practice.

Persistent Challenges in Scaling Independent Prescribing

1. Commissioning Gaps and Under-utilised Prescribers

Many pharmacists have completed IP training but lack funded, clearly defined roles in which to prescribe. Without recurrent commissioning and explicit posts, prescriber skills remain underused and morale is undermined. This mirrors earlier workforce initiatives where training outpaced structural change.

Delegates warned that if commissioning does not keep pace with the 2026 IP-enabled graduate cohort, the NHS risks a large cadre of prescribers unable to practise their full scope. This represents a waste of public investment in training, a missed opportunity to improve access for patients, and a source of frustration and demoralisation for pharmacists who are qualified but unsupported to use their skills.

2. Shortages of Designated Prescribing Practitioners

The pipeline of new prescribers is constrained by limited access to DPPs and unfunded supervision time. Many pharmacists rely on informal or goodwill arrangements to secure supervision, leading to inequity and slow progress. DPP shortages are particularly acute in community settings and underserved areas.

Participants highlighted the need for a structured, well-resourced national supervision model, rather than relying on ad hoc local arrangements that are neither scalable nor sustainable. Without predictable supervision capacity, the system risks sending a mixed

message to the workforce: encouraging pharmacists to train as prescribers but not creating conditions that allow that training to be completed and then applied in practice.

3. Pharmacy Technician Workforce Constraints

Pharmacy technicians are critical to freeing pharmacists from routine dispensing and administrative tasks. However, pay disparities, limited career progression and variable investment mean shortages are common. Without sufficient pharmacy technician support, pharmacists cannot dedicate time to clinical assessments, monitoring and prescribing, and IP remains "theoretical" rather than embedded in daily practice.

A stronger pharmacy technician pipeline is therefore not only a staffing issue but a prerequisite for realising the value of pharmacist prescribers – for patients, for system performance, and for pharmacists who want their roles to reflect their training and professional aspirations.

4. Fragmented Integration with Primary Care and Digital Systems

Relationships between community pharmacy and general practice vary widely across England. In some localities, pharmacists are recognised as equal partners; in others, they remain peripheral. Lack of shared access to digital health records and interoperable systems further impedes safe prescribing, continuity of care and efficient referrals.

Delegates stressed that without routine, role-appropriate access to shared care records, community pharmacist prescribers cannot safely manage complex patients nor fully integrate into multidisciplinary pathways. When pharmacists are kept at the edges of information flows and local planning, the system loses both clinical capacity and workforce goodwill.

5. Limited Visibility in Policy and Workforce Planning

Community pharmacy is still insufficiently visible in some national primary care strategies and workforce plans. Delegates reported that pharmacy is sometimes referenced generically but not explicitly embedded in mainstream planning and investment frameworks for IP, neighbourhood teams or ICS-level transformation. This weakens advocacy for funding and undermines consistent commissioning of IP services.

To move pharmacists from the margins to the centre of delivery, strategy and commissioning frameworks must treat community pharmacy IP as a core part of the multidisciplinary workforce, with clear expectations, metrics and investment.

6. Cultural and Perceptual Barriers

Persistent misconceptions about pharmacists' clinical capabilities, and uncertainty about the safety of pharmacist prescribing, continue to shape attitudes among policymakers, clinicians and patients. These perceptions rarely align with the established evidence base and international experience; however, they significantly impact local decisions-making, commissioning interest and inter-professional dynamics.

Delegates agreed that without targeted, evidence-led efforts to address these myths, IP risks remaining seen as marginal or high risk, rather than a proven, mainstream solution. This not only limits patient access to pharmacist-led care but also affects the confidence and professional identity of pharmacists whose extended role is not always recognised or trusted.

Strategic Priorities for Change

Drawing on UK experience and international case studies, the roundtable identified several strategic priorities to support safe, scalable and sustainable IP in community pharmacy, while valuing the pharmacy workforce as a key asset in delivering the NHS 10-Year Plan.

1. Establish a National Commissioning Framework for Independent Prescribing

A national framework should:

- Provide ring-fenced, recurrent funding for community pharmacy IP services linked to population need and measurable outcomes (e.g. General Practitioner (GP) appointment deflection, better disease control, reduced urgent care use, and improved workforce retention and satisfaction).
- Embed IP roles within ICS workforce plans, ensuring IP posts are recognised, costed and sustained.
- Evolve existing schemes (such as Additional Roles Reimbursement Scheme) towards strategic commissioning of capability, enabling funds to support community pharmacy IP posts as well as practice-based roles.
- Support flexible, outcome-focused contracts rather than narrow, condition-specific or short-term pilots, giving pharmacists the stability and clarity needed to plan careers around IP.

2. Build a Structured Designated Prescribing Practitioner and Supervision Infrastructure

To remove current training bottlenecks, the NHS should implement a national supervision model that includes:

- Regional DPP hubs at ICB or Training Hub level, coordinating supervisor allocation, quality assurance and governance across sectors.
- A digital supervision platform to match trainees and DPPs, document progress and support remote or blended supervision.
- Funded supervision time and incentives embedded into contracts and workforce budgets to recognise DPP workload.
- A staged "pay-it-forward" progression pathway enabling experienced pharmacist prescribers to move into supervision roles with appropriate support, reinforcing a culture where pharmacists are supported to develop and then support others.

3. Invest in the Pharmacy Technician Pipeline

A coherent workforce strategy for pharmacy technicians is needed to unlock pharmacist capacity. This should include:

- Expansion of training places and apprenticeships.
- Clear, nationally recognised career frameworks and progression routes.
- Pay structures that support recruitment and retention.
- Integration of technicians into ICS workforce planning as a core component of the pharmacy team.

Strengthening the technician workforce will enable pharmacists to shift their time towards clinical care and prescribing, ensuring that IP capability translates into real service change for patients and the wider system.

4. Embed Community Pharmacy Independent Prescribing in Primary Care Pathways

To ensure integration rather than fragmentation, community pharmacy IP should be:

- Co-designed and co-commissioned with PCNs and GP practices, with shared outcomes and aligned care pathways.
- Supported by routine access to shared care records and interoperable digital tools for all primary care pharmacists.
- Reflected in ICS governance structures, with senior pharmacy leaders holding formal roles in medicines optimisation, primary care transformation and workforce boards.

This approach positions pharmacists as full members of multidisciplinary teams, rather than “add-ons”, and gives the workforce a clear, visible role in managing demand across the system.

5. Design Flexible, Outcomes-Based Service Models

Commissioning should focus on patient outcomes and clinical capability rather than tightly constrained service lists. National standards can set the framework for safety and equity, while allowing local systems to tailor service scope to population needs.

IP should be treated as a core workforce capability, not solely linked to individual pilot pathways or single disease areas. Flexible models can create space for pharmacists to build confidence and competence over time, with clear expectations and support from employers.

6. Strengthen Public Trust and Professional Recognition

A coordinated trust-building approach should:

- Run national and local communication campaigns explaining pharmacist training, scope of practice and the role of IP.
- Routinely publish comparable outcome data on safety, patient experience, clinical measures and system impact for pharmacist-led IP services.
- Use case studies and exemplars to dispel myths and highlight success stories, both for professional audiences and the public.

Visible evidence of impact helps reassure patients and other professionals, supports commissioners to invest, and reinforces the value of IP to pharmacists themselves.

Key Insights

From the roundtable discussions, six headline insights emerged:

1. IP is central to the NHS 10-Year Plan, not a peripheral innovation. If pharmacy IP is not fully integrated into planning, the system will struggle to meet demand for accessible, preventive, community-based care.
2. The main constraints are structural, not clinical. Pharmacists are ready and able to prescribe safely; the barriers lie in commissioning, supervision, workforce support and digital access.
3. Supervision capacity is a critical bottleneck. Without funded, structured DPP models, training pipelines cannot meet future workforce needs and early-career prescribers may become disillusioned.

4. Pharmacy technicians are essential enablers. Investment in this workforce is a prerequisite for freeing pharmacists to deliver clinical IP services on a scale.
5. Integration with general practice and ICS governance is uneven but achievable. Where pharmacists are embedded in teams, outcomes, relationships and workforce experience improve; where they are not, patients experience fragmentation and pharmacist skills are underused.
6. Cultural change requires evidence and visibility. Publishing robust IP outcome data and embedding pharmacy within national policy frameworks are vital to shift perceptions, secure lasting support and demonstrate to pharmacists that their expanded role is recognised and valued.

Recommendations

The following recommendations are directed at key stakeholder groups.

For NHS England and the Department of Health and Social Care:

- Develop and implement a national commissioning framework for community pharmacy IP, with ring-fenced funding from 2026/27 onwards.
- Embed community pharmacy IP within national workforce strategies and the NHS 10-Year Plan delivery architecture, including clear targets for IP deployment in community settings.
- Establish a national DPP and supervision infrastructure, including regional hubs, digital platforms and funded supervisory capacity.
- Ensure IP is fully reflected within forthcoming updates to national digital, data and primary care strategies, with explicit recognition of the workforce implications and opportunities.

For ICBs and ICSs:

- Include community pharmacy IP explicitly within ICS workforce plans, neighbourhood models and medicines optimisation strategies.
- Co-design IP service specifications with PCNs, community pharmacy providers and local professional networks, ensuring alignment with local population-health priorities.
- Provide role-appropriate access to shared care records for all primary care pharmacists and embed pharmacy representation in ICS governance forums.

For PCNs and Local Commissioners:

- Move from ad hoc pilots to multi-year, outcomes-based contracts for community pharmacy IP services.
- Integrate IP within local pathways for minor illness, long-term conditions, contraception, deprescribing and urgent care.
- Develop joint clinical governance arrangements across GPs and pharmacists to support safe, coordinated prescribing and shared accountability.

For Pharmacy Leadership and Professional Bodies (e.g. Royal Pharmaceutical Society, National Pharmacy Association and others):

- Provide clear professional standards, guidance and curricula for community-based IP, supervision and multidisciplinary working.
- Lead advocacy and myth-busting campaigns, showcasing IP success stories and outcome data for patients, the health system and the workforce.
- Support the development of leadership capabilities among pharmacist prescribers, including quality improvement and service redesign skills.

For Educational Institutions and Training Providers:

- Align Initial Education and Training of Pharmacists and post-registration programmes with the realities of community IP, including inter-professional education and digital competencies.
- Expand access to IP training places, particularly for community pharmacists, and work closely with ICS Training Hubs and regional DPP structures to ensure supervised learning is feasible.

For Industry Partners and Technology Providers:

- Co-develop digital tools, decision-support systems and shared-record solutions optimised for community pharmacy IP.
- Support evaluation and evidence generation on IP impact through data analytics, implementation research and innovation partnerships, making pharmacist contributions more visible to policymakers and the public.

Attendees of Roundtable Two

This brief is informed by a roundtable held on 1 July 2025 under the Chatham House Rule. Twenty-six delegates participated, including community pharmacists, independent prescribers, workforce leads, ICB and NHS England representatives,

professional leaders, and academic and consultancy experts. Their lived experience and insights underpin the analysis and recommendations presented here.

Figure 1: Roundtable 2 Participants Job Category

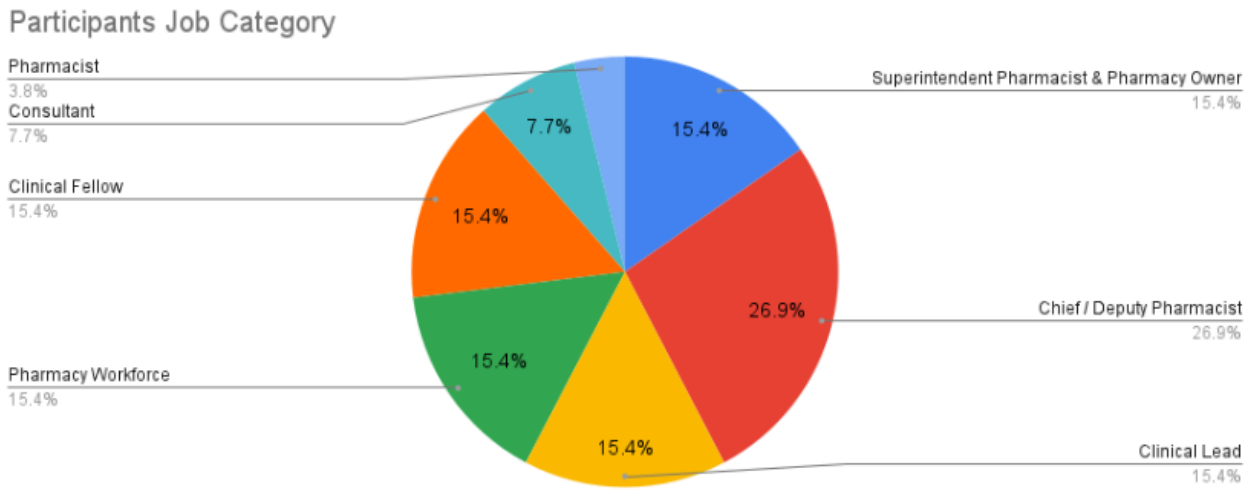
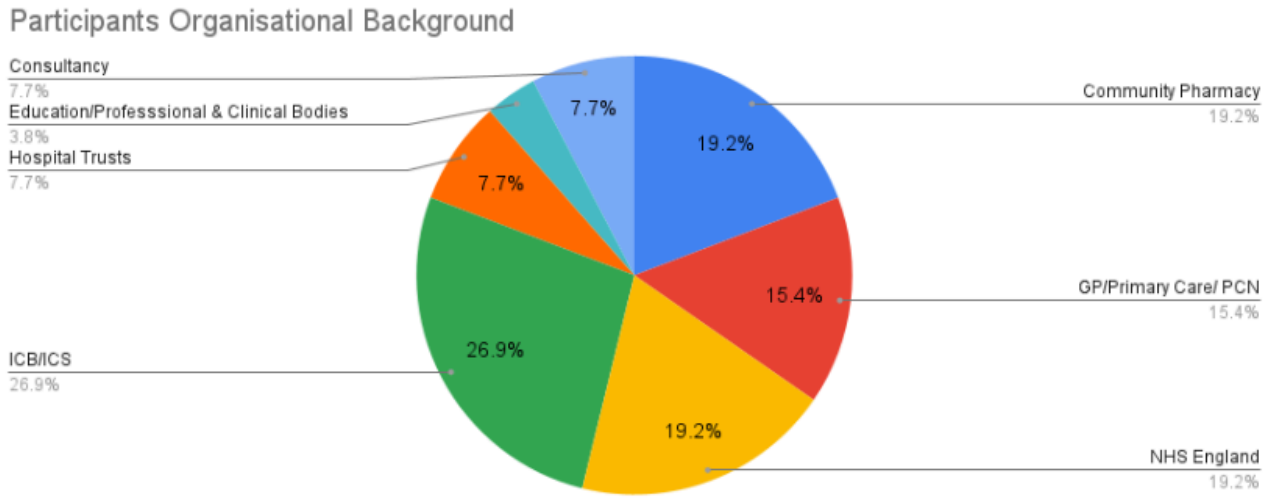


Figure 2: Roundtable 2 Participants Organisational Background



Abbreviations

DPP – Designated Prescribing Practitioner
ICB – Integrated Care Board
ICS – Integrated Care System
IP – Independent Prescribing
NHS – National Health Service
PCN – Primary Care Network
UK – United Kingdom

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