



Research report September 2023

A vision for community pharmacy

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Executive summary

The King's Fund and the Nuffield Trust were commissioned by Community Pharmacy England to develop a vision for community pharmacy that will underpin a strategy for the sector and support Community Pharmacy England in its leadership role, its work with members and in negotiations. Our independent report describes that vision and the actions which will be required to turn the vision into reality.

It sets out the scale of ambition for community pharmacy, in particular showing how community pharmacy can contribute to key policy goals around population health, prevention and increasing levels of demand in primary care. It also explores the barriers which have held progress back in the past and will need to be addressed to achieve the vision, and the enablers which give us confidence that progress can be made now.

The future pharmacy vision

This vision document is being published at a time of unprecedented challenge for the health and care system in England. The health and care needs of the population are changing. People are living longer with multiple, complex, long-term conditions and increasingly require long-term support from many different services and professionals. Community pharmacy, like all parts of the health and care system, needs to adapt to meet those needs.

Over the course of the next decade, community pharmacy will undergo significant transformation, becoming central to the delivery of joined-up, responsive and person-centred community-based health and care services, with increased investment from commissioners reflecting the increased significance of community pharmacy in the health care ecosystem.

Patients and the public will be able to access medicines, further clinical services and preventive services which are accessible and clearly understandable, and that give them choice where appropriate, continuity where required, and

confidence in the advice and treatments they receive. Community pharmacies will play a particularly important role in supporting self-care and helping their local populations to stay healthy and well. The growth of the independent prescriber role will mean that a large proportion of patients with self-limiting conditions will use community pharmacy as their first contact point for treatment and advice. And the services offered by community pharmacy will be integrated with other parts of the health and care system, particularly other parts of primary care, with information and pathways flowing seamlessly across different providers and settings. This will ensure that patients that need to be directed to other appropriate services can be quickly directed to the right part of the system.

Community pharmacy will make a significant and valued contribution to the goals of the wider health and care system, including the ambitions of their local integrated care board (ICB). It will have a key role to play in addressing inequalities, both in health status and in access to health care.

Pharmacies will be thriving businesses, continuing with their core role as a key part of the medicines supply chain in purchasing and dispensing drugs, while broadening the range of contracted and funded activities they undertake. They will be able to offer attractive careers with opportunities for training and development for pharmacists, pharmacy technicians and other support roles. Pharmacists will be valued members of multidisciplinary primary care teams, working with others to improve the health of their local populations.

From our starting point in 2023, we can see that there is clearly significant variation within the sector in terms of capacity and capability. In developing this vision, we have sought to design an approach which is deliverable by most community pharmacies, as we believe that this will mean that implementation is likely to be more successful. A national offer that is offered by all will be understandable to the public and may also avoid the frustration of people and patients being turned away from services. However, our framework also allows for those pharmacies with greater capacity to move further, faster.

There are four dimensions to the role of the future community pharmacy, all underpinned by a continuous improvement approach.

Preventing ill health and supporting wellbeing

Community pharmacies will play a key role in supporting people and communities to stay healthy and well, with a particular focus on reducing health inequalities.

Community pharmacies will offer much more than access to medicines, acting as local health and wellbeing hubs that support their communities to stay well and prevent ill health. This builds on existing initiatives, such as the development of Healthy Living Pharmacies. Community pharmacies will be an integral part of a wider integrated neighbourhood approach to population health and prevention. This might involve pharmacies themselves acting as local wellbeing hubs, or it might involve pharmacy teams supporting communities by reaching into other settings.

Providing clinical care for patients

Community pharmacies will have a much more clinically focused role, with members of the public consistently able to access care from community pharmacy teams for common conditions in a way that suits them and supports their health and wellbeing much more extensively than at present. This will expand on the emerging 'Pharmacy First' concept, with community pharmacists and their teams being seen by the public, and by other health care professionals, as a first port of call for many common ailments and some long-term conditions management.

The clinical service offer can be expanded over time as pharmacists build their skills and qualifications (including as independent prescribers), as the wider health and care system becomes more accustomed to community pharmacies playing a larger role in clinical care, and as clinical governance systems and regulatory frameworks are updated to support this.

Living well with medicines

Community pharmacy will support people to access and to live well with the medicines and treatments they are taking (including new and advanced therapies as they emerge) to improve outcomes, enhance safety and deliver better value.

This will be a core role of pharmacies and it will evolve to make best use of the current and future skills and expertise of the community pharmacy team, working in collaboration with general practice, patients and carers. It will build on existing evidence and best practice guidance on medicines optimisation and cost-effective use of medicines.

An integrated primary care offer for neighbourhoods

Community pharmacy teams will be an integral part of a local integrated primary care offer, working closely with local general practice, allowing people access to care in their own neighbourhoods, supporting patients with ongoing care needs in addition to preventive and acute care.

1 Introduction

The King’s Fund and the Nuffield Trust were commissioned by Community Pharmacy England (formerly the Pharmaceutical Services Negotiating Committee) to develop a vision for community pharmacy that will underpin a strategy for the sector and support Community Pharmacy England in its leadership role, work with members, and in negotiations with NHS England and the Department of Health and Social Care (DHSC). This independent report describes the vision for the sector and identifies the policies and other actions that will be needed to support its implementation. It sets out the scale of ambition for community pharmacy, in particular showing how community pharmacy can contribute to key policy goals around population health, prevention, and the increasing demand in primary care. The report also explores how the barriers that have held back progress in the past will need to be addressed to achieve the vision, and the enablers that give us confidence that progress can be made now.

Although many of the enablers for change in community pharmacy lie with the DHSC and NHS England, the importance of community pharmacy to the delivery of public health services should not be understated, and it will be important to ensure alignment between local authority and NHS commissioners. Integrated care systems (ICSs), bringing all key players together in a local area, are well placed to do that.

This report contains recommendations both for policymakers at a national level, and for local leaders in ICSs and local pharmaceutical committees as they work together to realise the vision for community pharmacy – a vision in which community pharmacy is central to the delivery of joined-up, responsive and person-centred community-based health and care services.

2 Our approach

This work was undertaken between October 2022 and August 2023. It consisted of several components.

- The Nuffield Trust and The King’s Fund undertook 49 semi-structured interviews between November 2022 and March 2023. These were completed in two phases. Phase one explored the current context of community pharmacy in England, the future vision, and the barriers and enablers to achieve that vision. Phase two tested emerging findings and explored implementation considerations in greater detail. Interviewees included representatives from across the community pharmacy sector as well as representatives from the wider health and care system, including primary care, integrated care boards (ICBs), local authorities, national bodies, representative organisations, education and academia, and other key stakeholders. Interviews were also undertaken with a small number of international pharmacy experts to explore models and learning from other systems.
- A literature scan was undertaken in April 2023 to identify and summarise literature relating to community pharmacy services, focusing on evidence on outcomes and cost-effectiveness; barriers to and enablers of community pharmacy service delivery; public views on community pharmacy; and potential opportunities for innovation. The scan also included targeted searches for England-specific research.
- A small steering group of experts from across the sector was convened to guide the work and act as a sounding board for the project.
- A broader expert advisory panel was constituted and chaired by the Nuffield Trust, bringing together members from within community pharmacy and the wider health care system. The advisory panel’s role was to provide challenge, advice and review at key stages in the process including shaping the lines of enquiry and testing initial findings and recommendations.

- Several thematic working groups were established by Community Pharmacy England around specific areas of interest, including digital and technology, workforce, services and funding. Discussions and outputs from these working groups were used to explore issues within each theme in greater depth.
- Community Pharmacy England undertook a wider consultation exercise to gather insights and perspectives on the vision. This included an online survey that ran for four weeks during November and December 2022, which received 151 responses. Community Pharmacy England also ran two online meetings, which pharmacy stakeholders could attend as an alternative to completing the online survey. The results of this engagement exercise were analysed by Community Pharmacy England and a thematic summary was shared with the Nuffield Trust and The King's Fund.
- Initial draft themes for the vision were developed by the Nuffield Trust and The King's Fund using insights from the interviews, the literature scan, the steering group, the advisory panel, working groups and the wider stakeholder engagement exercise. These were shared and discussed with the steering group to test and further develop the themes and recommendations.

3 Context

Community pharmacy now

In 2021/22, the latest year for which figures are available (NHSBSA 2022):

- there were 11,500 active community pharmacies, the lowest total since 2015/16*
- 308 new pharmacies opened and 418 closed
- 1.05 billion prescription items were dispensed, a 2.65% increase from 2020/21
- 95.3% of these were dispensed via the Electronic Prescription Service
- the cost of drugs and appliances reimbursed totalled £9.05 billion, a 0.83% increase from 2020/21
- 4.85 million seasonal influenza vaccines were administered, a 75.1% increase from 2.77 million in 2020/21

Current pressures on the health and care system

This vision document is being published at a time of unprecedented challenge for the health and care system in England. Demand is outstripping capacity for both routine and emergency care, with record numbers of people waiting for treatment (National Audit Office 2022). These pressures can be seen across all parts of the system, from hospitals to general practice to ambulance services. At the same time, workforce shortages across the NHS and social

* CPE data indicates the figure is now below 11,000.

care are impacting on services and increasing pressures on staff (The King's Fund 2023). Covid-19 undoubtedly exacerbated many of these issues, but most, if not all, pre-date the pandemic in some form or another. Public satisfaction with the NHS is at the lowest level ever recorded (Morris *et al* 2023). Improvements in life expectancy have slowed and health inequalities are widening (Williams *et al* 2022).

The health and care needs of the population are changing. People are living longer with multiple, complex, long-term conditions and increasingly require long-term support from many different services and professionals. Community pharmacy, like all parts of the health and care system, needs to adapt to meet those needs. Better integration of health and care services has been an objective of national policy for more than three decades, but progress towards delivering this ambition has been slow (National Audit Office 2017).

How the health and care system is changing

Significant changes are already under way to transform how the health and care system is organised. Integrated care systems (ICSs), established in July 2022, bring together NHS organisations, local authorities and others in partnership to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. Each ICS comprises two parts: an ICB, the statutory body responsible for planning and funding most NHS services in an area; and an integrated care partnership (ICP), a statutory committee that brings together a broad set of system partners (including local government, the voluntary, community and social enterprise sector (VCSE), NHS organisations and others) to develop a health and care strategy for the area (Charles 2022).

Within ICSs, much of the activity to integrate care, improve population health and tackle inequalities will be driven by commissioners and providers collaborating over smaller geographies (often referred to as 'places') and through teams delivering services working together on even smaller footprints (usually referred to as 'neighbourhoods').

These developments rest on the idea that traditional barriers – between hospitals, primary care and community services, between physical and mental

health, and between health and social care – need to be broken down to provide care that is much better integrated, so that people with multiple health conditions (not just single diseases) are better supported. It is also intended that these place-based approaches to care will support a much stronger emphasis on prevention, on population health, and on tackling the social and economic determinants of health and health inequalities (Buck *et al* 2018).

It is very early days for ICSs, and their ways of working are still under development (Timmins *et al* 2022). Depending on how the reforms are implemented, they could help support community pharmacy to adapt to meet the changing needs of the population and to become better integrated with the wider health and care system.

How primary care is changing

Community pharmacy, alongside general practice, optometry and dentistry, form the four pillars of primary care in England. Effective primary care is the bedrock of a high-quality and cost-effective health care system, but primary care in England is under significant strain. These pressures pre-date the Covid-19 pandemic and reflect wider pressures across the health and care system. They have also significantly intensified over recent months, with increased demand and decreasing patient satisfaction (Morris *et al* 2023).

General practices are being brought together to work at scale and in partnership with other health and care providers, including community pharmacy, within primary care networks (PCNs). This potentially provides an opportunity to improve the management of population health by providing a wider range of primary care services (Baird and Beech 2020). The Additional Roles Reimbursement Scheme (ARRS), available to PCNs since 2019, has also seen the rapid expansion of clinical pharmacists and pharmacy technicians working within general practice.

The Fuller Stocktake report (Fuller 2022) set out the next steps in integrating primary care services at a neighbourhood level and emphasised the increasing importance of community pharmacy at this level.

Responsibility for commissioning all four pillars of primary care has been transferred to ICBs from April 2023, with the aim of supporting the development of services that are responsive to local needs. Ahead of this, nine ICBs were selected as ‘early adopter’ commissioners, taking on delegated commissioning responsibilities from July 2022. Research into their experiences identified several transition challenges, including insufficient data, and capacity to analyse that data, around access and service quality, and a lack of effective engagement mechanisms with local providers (NHS Confederation 2023).

How community pharmacy is changing

Notwithstanding the developing skills in the community pharmacy sector, community pharmacy remains a relatively untapped clinical resource, as it is able to meet a wide range of patient needs and to work in partnership with GPs and other community-based health and care professionals. There are clear ambitions for community pharmacy, and the wider pharmacy sector, to take on more direct clinical work with patients (Picton *et al* 2022; Smith *et al* 2014), building on services already in place in some parts of the country, including support with healthy living, smoking cessation, contraception services and minor ailments.

The education and training of pharmacists is changing so that from 2026, all pharmacists will qualify as independent prescribers, together with enhanced clinical, population health and consultation skills. This means that they will be able to deliver more direct patient care. Pharmacy technician training also now provides a more clinical and patient focus (Picton *et al* 2022). In some places community pharmacists are already prescribers; this means they are able to treat people with self-limiting conditions or deliver contraception services (for example).

Funding arrangements have also changed to support the shift toward more clinical service delivery (Department of Health and Social Care 2022). In Scotland and Wales, community pharmacy delivery and contracting models have also changed to support this vision (Welsh Government 2021; Scottish Government 2017). These changes mirror developments in many countries that have already taken steps to move from a role dominated by dispensing

into a wider clinical role as part of integrated health and care systems – including Canada (Sears *et al* 2022), Australia (Dineen-Griffen *et al* 2020) and New Zealand (Raiche *et al* 2020).

Most recently, the delivery plan for recovering access to primary care published by NHS England in May 2023 includes a commitment to invest up to £645 million to expand community pharmacy services. This includes access to oral contraception, blood pressure checks, and the Common Conditions Service that enables pharmacists to supply prescription-only medicines, antibiotics and antivirals where clinically appropriate, to treat seven common health conditions without the need to visit a GP (NHS England 2023). NHS England will also support research to ensure a consistent approach to antibiotic and antiviral use between general practice and community pharmacy. The plan also recognises the need to invest in pharmacy information technology (IT) systems, as outlined later in this report.

The implementation issues highlighted in this report are not new. The *Community pharmacy clinical services review*, published in 2016, found that despite the case for change being well made, at least among policy-makers, there were significant barriers that were hampering implementation (Murray 2016). Seven years on, in our work, we can see that these issues are still very much present, albeit to a varying extent across the country. They include:

- insufficient resource across primary care as a whole, with new models of care reliant on shifting resource from one part of primary care to another, rather than overall investment
- finance and contracting arrangements that inhibit new models of pharmacy, with complex funding flows, atomised commissioning and fragmented contracts that are hard to manage
- perverse incentives that prohibit a shift away from dispensing
- poorly developed local relationships between professionals, which have continued to inhibit both integration and wider engagement
- insufficient management capacity and capability within community pharmacy and within ICBs

- a lack of patient data and interoperability to allow pharmacy staff to see, document and share clinical information about patient care with the clinical records held by other health care professionals
- the need to improve evidence on effectiveness, particularly cost-effectiveness
- some mistrust between primary care professionals, which can create a barrier to trust and collaboration
- public and patient expectations of community pharmacies that are limited to the dispensing of medications and retail.

However, the significant pressures on primary care, serious concerns from those at the top of government about difficulties in access to health services, the creation of ICSs, and growing awareness of the potential of community pharmacy all mean that now may be the time to overcome the barriers that have so far prevented the vision from being implemented.

4 Vision

We propose a vision for the future of community pharmacy that builds on a number of previous reports on this area* and a high level of consensus among the people who participated in our research. Many components of this vision are already being delivered by some leading pharmacies now, but over the next 10 years there will be more innovation and much wider adoption of the services envisioned here.

What will community pharmacy look like in 2033?

Over the course of the next decade, community pharmacy will undergo significant transformation, becoming central to the delivery of joined-up, responsive and person-centred community-based health and care services, with increased investment from commissioners reflecting the increased significance of community pharmacy in the health care ecosystem.

Patients and the public will be able to access medicines and other clinical services as well as preventive services that will be accessible and clearly understandable, offering choice where appropriate, continuity where required, and confidence in the advice and treatments they receive. Community pharmacies will play a key role in supporting self-care and helping their local populations to stay healthy. With the growth of the independent prescriber role, this will mean that a large proportion of patients with self-limiting conditions will use community pharmacy as their first contact point for treatment and advice. Community pharmacies will have a significant role in supporting people with long term conditions.

* Most recently, the Royal Pharmaceutical Society's vision for pharmacy professional practice in England set out ambitions for the entire pharmacy sector, including community pharmacy (Picton *et al* 2022).

The services offered by community pharmacy will be integrated with other parts of the health and care system, particularly other parts of primary care, with information and pathways flowing seamlessly across different providers and settings. This will ensure that people who need to be directed to other appropriate services can be quickly directed to the right part of the system, and similarly that people can be referred to their local pharmacy for support where appropriate.

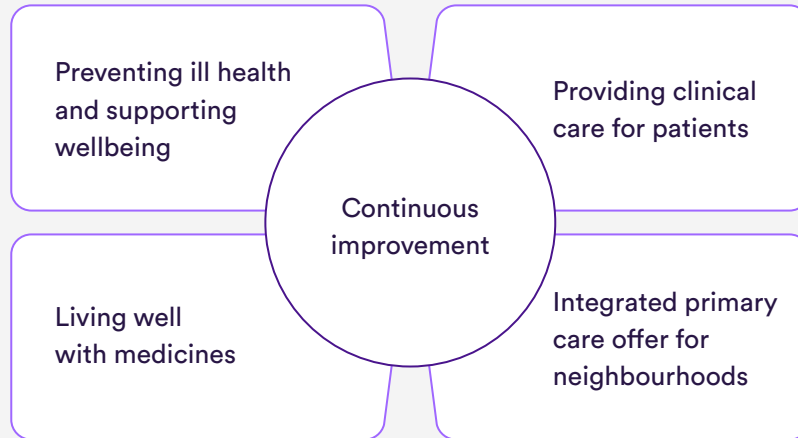
Pharmacies will develop more ways to interact with patients and the public, including through remote consultations, using new technologies such as advanced diagnostics, pharmacogenomics and wearables to supporting disease monitoring and prevention of ill health. We have not sought to forecast exactly what new innovations are likely to emerge over the coming 10 years, but rather to describe a framework and a culture within which community pharmacists will operate which will enable pharmacists and commissioners to work in partnership to make the most of innovations as they arise.

Pharmacies will be thriving businesses, continuing with their core role as a key part of the medicines supply chain in purchasing and dispensing drugs, while broadening the range of contracted and funded activities they undertake. Because of the financial fragility of many parts of the community pharmacy sector, it is important that core income is maintained. However, over the longer term the proportion of income relating to dispensing will fall, as funding for other services grows. We do not expect the quantum of cost relating to dispensing to fall significantly.

Pharmacies will be able to offer attractive careers with opportunities for training and development for pharmacists, pharmacy technicians and other support roles. Pharmacists will be valued members of multidisciplinary primary care teams, working with others to improve the health of their local populations.

Community pharmacy will make a significant and valued contribution to the goals of the wider health and care system, including the ambitions of their local ICB (see Figure 1).

Figure 1: Core components of the future community pharmacy offer



This vision is also consistent with views expressed by patient groups on the role of community pharmacy in meeting their needs. At a recent roundtable organised by National Voices, the umbrella organisation for charities in the health and care sector, participants identified areas in which they saw scope for pharmacies to offer enhanced support. These included:

- The potential to offer more services, including diagnostics and monitoring for people with long-term conditions.
- Continuity of care for both long-term conditions and people who need episodic care over their life course.
- Holistic care rooted in the needs of communities as well as individual patients.
- A ‘no wrong door’ approach to access and information on health issues so that patients are no longer ‘bounced’ between providers.

The recent ‘Public perceptions of community pharmacy’ report conducted by Ipsos on behalf of NHS England described a picture of considerable public confidence in community pharmacy, with scope to expand services in the future (see Box 1).

Box 1: ‘Public perceptions of community’ pharmacy report by Ipsos, September 2022

- Pharmacy users in England report positive experiences of community pharmacies. For example, on their last visit to a community pharmacy, most feel they were treated with respect (87%), were able to get what they needed (87%) and thought that the facility was clean and well maintained (87%).
 - Similarly, those who have used a pharmacy in the last year for advice about medicines, a health problem or injury, or what health service they should use, are overwhelmingly positive about the quality of the advice that they received. Nearly all (91%) say that they received good advice.
 - There are high levels of confidence in a pharmacist prescribing medication independently of a doctor or nurse when prescribing medicines a person has had before (77%) and for medication they are currently prescribed (70%).
 - Nearly all of the public (90%) say they would feel comfortable seeing a community pharmacist for a minor illness such as an earache, having spoken to the GP receptionist, instead of organising an appointment with their GP.
 - Similarly, most (90%) would be comfortable with being referred to a pharmacist for an appointment on the same day to discuss a minor illness following an online consultation with a nurse or GP.
-

Preventing ill health and supporting wellbeing

The ambition

Community pharmacies will play a key role in supporting people and communities to stay healthy and well, with a particular focus on reducing health inequalities.

What this will look like

Building on existing initiatives such as Healthy Living Pharmacies, community pharmacies will offer much more than access to medicines. They will act as local health and wellbeing hubs, supporting their local communities to stay well and prevent ill health.

Specific activities

- Public health interventions specifically designed for the community pharmacy context and existing points of interaction that allow for sensitive and confidential conversations, such as smoking cessation advice, weight management and alcohol advice as part of a range of interactions with patients and the wider public.
- Being a key source of smoking cessation advice and support, not only for tobacco products, but increasingly for vapes.
- Undertaking targeted health checks and screening for at-risk groups – for example, relating to blood pressure, body mass index (BMI) and cholesterol.
- Offering joined-up women’s health services – for example, emergency contraception medications and supply of regular contraception alongside chlamydia testing and referral to sexual health services, building on the existing government priority for pharmacies to play a key role in women’s health.
- Evidence-based advice on vitamin supplements.
- Supporting local vaccination offers, and delivering vaccinations where pharmacy is the most appropriate setting.
- Signposting and/or referring people on to other support such as social prescribing services.
- Taking action to reduce health inequalities and the priorities identified in local plans, such as integrated care and local joint health and wellbeing strategies, and national initiatives such as the Core20PLUS5 (five clinical areas against the 20% most deprived communities) approach to health inequalities.
- Over time, playing an increasing role in providing opportunities for early detection of ill health through advances in technology such as wearable diagnostics and point-of-care testing.

Community pharmacies will be an integral part of a wider integrated neighbourhood approach to population health and prevention. Depending on local circumstances this could involve pharmacies themselves acting as local wellbeing hubs or involve pharmacy teams supporting communities by reaching into other settings.

Using population health management principles to understand the needs and health risks within a given population, local commissioners (including both ICBs and local authorities) can target interventions and services, dialling up or down particular services and prevention offers depending on the distinct needs and priorities of an area or local population.

Community pharmacies have an important role to play in addressing health inequalities through offering a combination of open access and targeted services designed to meet the needs of local communities. The Core20PLUS5 approach includes a focus on five specific clinical areas. Within those, two are directly relevant to interventions delivered by community pharmacy:

- Chronic respiratory disease: community pharmacies playing a role in driving uptake of appropriate vaccination of people with chronic obstructive pulmonary disease (COPD) to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
- Hypertension case-finding and management and lipid management: allowing for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

Community pharmacies should take the lead in designing relevant Core20PLUS5 interventions in these areas. Community pharmacies may also have a role to play in two further clinical areas of Core20PLUS5:

- Severe mental illness (SMI): ensuring annual health checks for 60% of those living with SMI
- Improving early cancer diagnosis: ensuring 75% of cases of cancer are diagnosed at stage 1 or 2 by 2028.

Providing clinical care for patients

The ambition

Community pharmacies will have a much more clinically focused role, with members of the public consistently able to access care from community pharmacy teams for common conditions in a way that suits them and supports their health and wellbeing.

What this will look like

This will expand on the emerging Pharmacy First concept, with community pharmacists and their teams being seen by the public and by other health care professionals as a first port of call for many common ailments and some long-term conditions management. Community pharmacies will offer holistic, person-centred care, with consultations focused on principles of shared decision-making, empowering patients to make decisions about their medicines and their health and wellbeing. The Pharmacy Integration Programme has begun to test and evaluate new clinical pathways, and provides important experience to draw on. In addition, the development of the Major Conditions Strategy, the framework for which was published in August 2023, offers an opportunity for pharmacists to be engaged at all stages in the prevention, diagnosis and treatment of long-term conditions.

Specific activities

- Diagnosing and managing a wide range of acute common ailments, including prescribing medications to treat these when clinically appropriate. This will include common minor conditions such as acne, athlete's foot, chickenpox, conjunctivitis, haemorrhoids, hay fever, urinary tract infections and thrush (among others).
- Supporting the identification and management of some common long-term conditions such as asthma and diabetes, including disease monitoring and optimising the use of medicines and devices.
- Case-finding, initial prescription and titration for hypertension, plus ongoing management of hypertension.
- Supporting patients with effective self-management of their conditions, through providing high-quality advice and guidance.

- Being able to refer people to other services and settings when clinically indicated – pharmacists should be able to refer directly for diagnostics, eg blood tests and to secondary care where appropriate, rather than sending patients back to their GP.
- Identifying red-flag symptoms indicative of more serious illness, and signposting or referring patients for a more comprehensive clinical assessment when these are present.
- Supporting access by maintaining the walk-in nature of community pharmacies, while also offering some longer consultations on an appointment basis. This could also include the use of digital technologies to enable patients to remotely access the services provided.

A degree of consistency in the core services offered, together with a clear communication of this offer, will be needed so that people know when and how to access services, and so that other health professionals understand what is available and how to signpost people to this support.

The scope of the services on offer can be expanded over time as pharmacists build their skills and qualifications (including as independent prescribers) and as the wider health and care system becomes more accustomed to (and confident in) community pharmacies playing a larger role in clinical care, and as clinical governance systems and regulatory frameworks are updated to support this.

Living well with medicines

The ambition

Community pharmacy will support people to access and to live well with their medicines and treatments, including new and advanced therapies whenever they emerge. This will improve outcomes, enhance safety and deliver better value.

What this will look like

This is the core role of pharmacies and it will evolve to make best use of the current and future skills and expertise of the community pharmacy

team, working in collaboration with general practice, patients and carers. It will build on existing evidence and best practice guidance on medicines optimisation and cost-effective use of medicines (Department of Health and Social Care 2021).

Specific activities

- Ensuring that pharmacy technicians have the skills and ability to provide much of the dispensing role and therefore free up pharmacist capacity to focus more on the complex and high-risk medications.
- Community pharmacists playing an increasing role in medicines optimisation services, providing services such as new medicines, discharge medicines and variation analysis.
- Playing a central role in the wider use of pharmacogenetics and greater personalisation of medications, particularly around management of long-term conditions.
- Incentivising community pharmacists to work with patients and the public to support adherence to medication regimes and reduce waste.
- Where appropriate, providing in-reach services to settings such as care homes to support providers in optimising medicines management.

Much of this work will be enabled by community pharmacy working in partnership with place-based multidisciplinary teams across primary care.

Part of an integrated primary care offer for neighbourhoods

The ambition

Community pharmacy teams will be an integral part of a local integrated primary care offer, allowing people access to care in their own neighbourhoods and supporting people with ongoing care needs in addition to preventive and acute care.

What this will look like

Commissioners will take account of primary care services in the round when making commissioning decisions. Community pharmacies will become

integral members of primary care networks (PCNs) and multidisciplinary teams, with financial incentives to support collaboration rather than to foster competition between elements of the primary care system. Data and communications systems will allow shared patient care between all professionals in the team.

Specific activities

- Community pharmacies taking a co-ordinated and active role in the work of PCNs.
- Agreeing principles and protocols for data sharing between different providers in the neighbourhood, including community pharmacy.
- Considering the primary care estate in the round when thinking about the locations available for the delivery of community-based health and care across local neighbourhoods.
- Better aligning contracts to ensure that collaboration is incentivised and supported.

Continuous improvement

The ambition

Community pharmacy has a skilled workforce providing high-quality services and is continuously developing and improving the way in which patients, the public and health care professionals are supported.

What this will look like

There will be a comprehensive workforce plan for community pharmacy at national and local levels. Community pharmacists and their teams have rewarding careers, with ongoing professional development and opportunities for improvement. Quality improvement approaches will be embedded within community pharmacy teams, who have access to external skills, support and data as needed to ensure change and improvement, together with appropriate assurance and regulation.

Specific activities

- Community pharmacy being embedded in the national workforce plan for the NHS.
- ICBs ensuring that community pharmacy is included in local workforce plans.
- Developing a structured post-registration career roadmap for pharmacists and pharmacy technicians with post-registration curricula and frameworks recognised and funded as appropriate by NHS England, employers and regulators.
- Use of comprehensive data on the pharmacy workforce at ICB level to enable workforce planning for all pharmacy staff groups, clinical and non-clinical, on an ongoing basis.
- ICBs developing effective infrastructure to support the development of community pharmacy at local level, in partnership with providers, including data analytics and change management support.

5 Implementing the vision

As noted, there was strong consensus among those involved in our work around the vision for community pharmacy, and it echoes much of what has been written previously. In this section we explore what it will take to make that vision a reality, focusing on the key barriers and outstanding issues that need to be resolved. We found much less consensus among interviewees on detailed questions of implementation and, in some cases, very divergent views on potential solutions. Despite these different perspectives, it is clear that a shared strategy must be developed. For each set of issues, we have proposed the solutions and actions that we feel are most appropriate, being both ambitious for the future and rooted in current realities. We have then provided some commentary that illustrates the detailed issues which lie behind our proposals and, where relevant, the range of perspectives we heard. A full set of actions required, listed by responsible body, is included in Annex A. Many of the actions set out in this report for NHS England and DHSC will naturally require strong engagement from pharmacy leaders at both local and national level to realise their full benefit, and we anticipate that CPE will address this in their forthcoming strategy.

We believe that the most future-proof approach is likely to be one that tries to make progress on these issues relatively quickly, including allowing some community pharmacies, places and ICBs to test the developments listed here and others as they emerge over time. We propose a framework which helps community pharmacists and commissioners to make the most of the skills and experience currently existing in community pharmacy and to build on that in future years, incorporating new developments in the workforce, in technology and in creative approaches to working in partnership with other primary and secondary care professionals.

Many community pharmacists are keen to make progress on delivering new services quickly, and where the necessary skills and resources exist to enable this, the framework we propose should allow them to make rapid progress. In some places the priority will need to be a focus on getting the basic infrastructure of community pharmacy right, so that community

pharmacies are able to deliver core services within the resources available to commissioners, and implement the changes described in the primary care recovery plan (NHS England 2023).

Embedding a new approach to service delivery over time

The NHS contractual framework for the delivery of community pharmacy services will need to be revisited to deliver this vision. All pharmacies will be expected to be able to offer a wide range of services that will be nationally specified and priced. These need to be available consistently in all locations. Pharmacies will be able to opt to do more than this, in agreement with their local commissioners, drawing from a nationally agreed menu of additional services and to develop and agree other additional services to meet local needs.

The following two tables set out a potential view of services which could be delivered by community pharmacists over the next five years, and in five to ten years.

This course of action builds on the current contractual framework for community pharmacy services in England, moving some services that are currently defined as ‘Advanced’ into the ‘Essential’ category, and adding new services into the ‘Enhanced’ category. Our expectation is that this progression will continue in future years, with the menu of services kept under review so that as those services currently described as ‘Advanced’ become the norm, they will move into the ‘essential’ category and be replaced by services which might currently be regarded as new and innovative and funded as ‘Enhanced’ services. In turn, we expect that new enhanced services will be identified through local piloting and testing and agreed for future inclusion. This is represented by the text in red in Table 2, which highlights services which have moved, eg from ‘Advanced’ to ‘Essential’.

While some of these additional services may seem unambitious to pharmacies that are already delivering them, there is clearly significant variation within the sector in terms of capacity and capability. Starting implementation of a

new approach deliverable by most community pharmacies will mean that implementation is likely to be more successful. A national offer that is offered by all will be understandable to the public and may also avoid the frustration of people and patients being turned away from services. We expect that commissioners will encourage as many pharmacies as possible to deliver both essential and advanced services from the outset.

We recognise that increasingly, some groups of patients are choosing distance selling pharmacies to obtain their medicines. On balance, we do not believe that distance selling pharmacies should have a separate contractual arrangement, but they may need to make arrangements with other partners in order to fulfil all aspects of the core contract for Essential services.

The relatively new concept of National Enhanced services is designed to mitigate the impact of the current lack of capacity in many ICBs to undertake the service specification and pricing work required. Realistically, given the state of preparedness within ICBs, additional Local Enhanced services are likely to be relatively rare in the early years of implementation, except in those few areas where they are already in place. However, this category provides an opportunity for piloting and testing services with a view to adding them to the 'Essential' or 'Advanced' categories in future.

Table 1: Services to be delivered over the next five years

Essential services	Advanced services
<p>Nationally specified and priced, provided by all community pharmacies, bringing greater consistency for patients</p>	<p>Nationally specified and priced, provided by community pharmacies able to do so, bringing greater consistency for patients</p>
<p>All services included as Essential services in the current Community Pharmacy Contractual Framework (CPCF), plus:</p>	<ul style="list-style-type: none"> Pharmacy contraception service, with the addition of LARC and emergency contraception (independent prescribing)
<ul style="list-style-type: none"> Enhanced Healthy Living Pharmacy activities (incorporating social prescribing), working collaboratively with primary care networks Community pharmacist consultation service, including a walk-in consultation option for patients Common conditions service – supply of medicines, such as antimicrobials (independent prescribing) and supply of over-the-counter medicines to patients eligible for free prescriptions on low income grounds New medicine service Deprescribing and amendment of prescriptions (independent prescribing), such as: <ol style="list-style-type: none"> synchronisation of prescriptions interventions to improve adherence optimisation of therapy with formulation changes amendment of treatment to address supply chain shortages 	<ul style="list-style-type: none"> Smoking cessation service, expanded to provide open-access support to all smokers and users of vapes Flu vaccination service COVID-19 vaccination service Hypertension case-finding service, with the addition of atrial fibrillation detection Cancer detection and referrals Appliance use reviews and stoma appliance customisation

Enhanced services – national

Nationally specified and priced, provided by local agreement with the NHS commissioner. Examples might include:

- Vaccination services (beyond flu and COVID-19)
- Weight management service
- Management of single long-term conditions (independent prescribing), e.g. hypertension, lipid control, asthma (including annual asthma reviews)
- Medicines optimisation services (independent prescribing), including initiation of electronic repeat dispensing, structured medication review, pharmaceutical care plan, therapeutic drug monitoring and pharmacogenomics

Enhanced services – local

Locally specified and priced, provided by local agreement with the NHS commissioner. Examples might include:

- Direct input into primary care networks, including taking on clinical pharmacist roles
- Management of multiple long-term conditions (independent prescribing)
- Cancer detection and referrals
- Point of care testing and phlebotomy, including treatment of conditions in some cases
- COPD case-finding service
- Health checks for specific target groups (e.g. for diabetes), using point of care testing with follow-up and a personalised wellbeing plan
- Remote/rural services
- Care home support

Clinical services pilots

Services which could be piloted to inform future NHS commissioning. Examples might include:

- Management of minor injuries
- Annual asthma reviews
- Menopause advice service, including supply of HRT (independent prescribing)
- Diabetes check service (annual disease checks and medicines optimisation)
- Dermatology service (eczema, acne and psoriasis management)
- Pain management service
- Depression and anxiety management service (medicines optimisation)

Local government services

Locally specified and priced, provided by local agreement with the commissioner. Existing examples include:

- Substance use services, incl. supervised consumption, needle and syringe services, naloxone supply
 - NHS Health Checks
 - Smoking and nicotine cessation service
 - Weight management services
 - Sexual health and contraception services
 - Alcohol screening & brief intervention
 - Adherence support services for housebound patients
-

Table 2: Services to be delivered over the next five to 10 years

Essential services	Advanced services
<p>Nationally specified and priced, provided by all community pharmacies, bringing greater consistency for patients</p>	<p>Nationally specified and priced, provided by community pharmacies able to do so, bringing greater consistency for patients</p>
<p>All services included as Essential services in the current Community Pharmacy Contractual Framework (CPCF), plus:</p>	<ul style="list-style-type: none"> Pharmacy Contraception Service, including the provision of LARC and emergency contraception (independent prescribing)
<ul style="list-style-type: none"> Enhanced Healthy Living Pharmacy activities (incorporating social prescribing working collaboratively with primary care networks) Community pharmacist consultation service, including a walk-in consultation option for patients Common conditions service New medicine service Deprescribing and amendment of prescriptions (independent prescribing), such as: <ol style="list-style-type: none"> synchronisation of prescriptions interventions to improve adherence optimisation of therapy with formulation changes amendment of treatment to address supply chain shortages Hypertension and atrial fibrillation case-finding service Flu and COVID-19 vaccination service Cancer detection and referrals 	<ul style="list-style-type: none"> Smoking Cessation Service, expanded to provide open-access support to all smokers and users of vapes Vaccination services (beyond flu and COVID-19), including childhood vaccinations Management of single and multiple long-term conditions (independent prescribing) Medicines optimisation services (independent prescribing), including: <ol style="list-style-type: none"> initiation of electronic repeat dispensing structured medication review pharmaceutical care plan therapeutic drug monitoring pharmacogenomics Menopause advice service, including prescribing of HRT (independent prescribing) NHS Health Checks Appliance use reviews and stoma appliance customisation

Enhanced services – national

Nationally specified and priced, provided by local agreement with the NHS commissioner. Examples might include:

- Weight management service
- Annual asthma reviews
- Management of minor injuries
- COPD case-finding service
- Health checks for specific target groups (e.g. for diabetes), using point of care testing with follow-up and a personalised wellbeing plan
- Diabetes check service (annual disease checks and medicines optimisation)
- Dermatology service (eczema, acne and psoriasis management)
- Pain management service
- Depression and anxiety management service (medicines optimisation)

Enhanced services – local

Locally specified and priced, provided by local agreement with the NHS commissioner. Examples might include:

- Direct input into primary care networks, including taking on clinical pharmacist roles
- Point of care testing and phlebotomy, including treatment of conditions in some cases
- Remote/rural services
- Care home support

Clinical services pilots

Services which could be piloted to inform future NHS commissioning. Examples might include:

- Advances in pharmacogenomics

Local government services

Locally specified and priced, provided by local agreement with the commissioner. Existing examples include:

- Substance use services, including supervised consumption, needle and syringe services, naloxone supply
 - NHS Health Checks
 - Smoking and nicotine cessation service
 - Weight management services
 - Sexual health and contraception services
 - Alcohol screening & brief intervention
 - Adherence support services for housebound patients
-

Note: Text in red denotes services which have moved, eg from ‘Advanced’ to ‘Essential’ or vice versa.

Contracting, commissioning and business models

Actions required

Specific actions needed to support implementation of the development to the contractual framework described above include the following:

- NHS England and Community Pharmacy England to set out a timetable for the renegotiation of the community pharmacy contractual framework (NHS England, DHSC, Community Pharmacy England)
- Comprehensive agreement at national level about how community pharmacy fits with the broader primary care strategy, removing some of the zero-sum elements of current approaches where resources are moved between community pharmacy and general practice (NHS England, DHSC).
- Significant focus on building capacity and capability in commissioning at national level, and for community pharmacies to collaborate both to negotiate service patterns and to agree contracts (NHS England, Community Pharmacy England).
- Supporting collaboration with GPs and the wider health and care system. In particular, while pilots of services should be in areas where local agreement can be reached and the impact across the whole pathway tested. NHS England will need to take responsibility for evaluating such pilots and for bringing findings together to ensure future contract development (NHS England).
- Performance measures included in the framework should, where possible, consider patient experience and/or outcomes as well as activity levels. This is likely to require some piloting to develop (NHS England).
- There should be consideration of incentives to facilitate local-level collaboration (eg, payments to free up pharmacy and GP time to come together to identify local issues where working together could deliver value-based care) (NHS England and ICS leaders).

- There is also a need for clear guidance and oversight on conflicts of interest, particularly for the prescribing and dispensing roles and commercial interests (eg, when the evidence goes against provision of medication or other pharmacy items) (DHSC and General Pharmaceutical Council).
- Clearer understanding of how to ensure oversight and strategic planning of market entry and exit, both at the national and the local level. Some national market oversight will be required, analogous to the current role of the Care Quality Commission (CQC) in oversight of the care sector. This combined with active market management at local level is likely to result in some market exit (NHS England, DHSC and ICS leaders).
- As discussed below, implementing this vision will require additional resources, so agreements will be needed to ensure that savings in the sector will be recycled back into community pharmacy to remove disincentives to de-prescribe, or change dispensing intervals (DHSC and NHS England).
- Investment in IT to ensure that any provider offering advanced or enhanced services has access to the National Care Records Service and additionally to ICB-level shared care records, so that information from pharmacy systems can be shared to those records, and has access to the GP care record where that provides necessary access to information (NHS England, ICS leaders).
- The agreement of clear, direct referral pathways where appropriate, together with simple systems for referring between elements of primary care to avoid patients feeling ‘bounced’ around different elements of the system. This should include the relevant underpinning IT systems, building on the point above (ICS leaders).

Discussion

It was clear from our work that there are complex and interrelated issues around how community pharmacy is contracted and commissioned that need to be addressed. The significant financial challenge in the community pharmacy sector, as well as the wider primary care sector, was reiterated by most interviewees and can be clearly seen in the available data (Ernst & Young LLP 2020). Financial viability is a clear issue for many community pharmacies

and several of the multiples and larger chains have implemented major disinvestment programmes. Added to this, the complexity of the economic framework of community pharmacy and uncertainty about the future – particularly of the balance of dispensing versus provision of clinical services – has led to significant levels of uncertainty in the market, with little incentive for investment in the future. Without effective commissioning and market management, there is a danger that economic pressures will drive closures without reference to the community pharmacy needs assessment, ICB plans or public consultation.

Many of our interviewees spoke about the potential for developing ‘hub and spoke’ dispensing models and noted the increased use of distance selling pharmacies by patients. We recognise this as a legitimate response to some of the pressures facing local pharmacies, although as noted above, distance selling pharmacies would still need to be able to deliver the requirements of the core Essential Services contract, and it will be important that commissioners ensure there are sufficient financially viable in person providers in their area. Regulatory changes would be required in order to deliver the most efficient working models, and this is discussed further below.

There was a consistent view among our interviewees that the current community pharmacy contractual framework does not contain the right incentives to drive progress towards the future vision for community pharmacy. There were, however, divergent views on what funding approach should be adopted in the contract. Some interviewees advocated for at least a partial use of patient registration that would then allow for some capitated funding to be given to community pharmacy, allowing a move away from a fee-for-service model. Others suggested that the strength of the community pharmacy sector was its accessibility, with patients and the public able to attend any pharmacy, and so did not think that registration and capitation would be appropriate.

The extent to which incentive payments might be used for meeting quality measures was also debated, but there was a clear acknowledgement that the extent to which any measures overlap with Quality and Outcomes Framework (QOF) incentives for GP practices would be problematic, creating unhelpful competition for the resource between the two sectors.

Whichever model is chosen, many interviewees spoke of the need for greater alignment between different primary care contracts, along with increased strategic oversight of the commissioning of the primary care sector as a whole. There was strong agreement that the way in which GP and community pharmacy national contracts are constructed in particular causes unhelpful tension and competition, and disincentivises collaboration. There was consensus that incentivising collaboration within primary care, and between pharmacies, will require investment to build capacity across the primary care sector, rather than moving money from one part of the sector to another. Without this, suspicion that others are getting a better deal is likely to pervade.

Steering Group and Advisory panel discussions also highlighted the need to ensure alignment between NHS commissioners and their local authority colleagues, particularly as pharmacies are commissioned to deliver more preventive care and public health programmes. Although this report does not look in detail at the role of local authorities as the commissioner of public health services, ICSs are well placed to ensure that alignment at a local level.

While there was broad agreement on the need for a core national offer of some kind, the issue of capacity and capability of commissioners, both at national and local level, is key. With both elements of the system facing headcount reductions, there was little confidence that commissioners have the capacity, capability or necessary levers to effect change in community pharmacy.

Those we interviewed felt that community pharmacy is often considered in isolation at best, and at worst given scant consideration by commissioners. Although the current pharmacy needs assessment approach could be used as a tool to build a planned local approach to pharmacy, there would need to be harmonisation if there are multiple local authorities within one ICB area. Concerns were also raised that the pharmacy needs assessment is sometimes not viewed as a priority by commissioners, partly reflecting a perceived distrust among commissioners of the retail and commercial sides of pharmacy.

Although the ability of ICBs to take on delegated commissioning to better meet local need is core to national policy, this local flexibility was the cause of some issues. Having small local contracts, even with the same commissioner, with different monitoring, administration and payment mechanisms is

burdensome, both to large and small multiple chain providers but also to small independent providers. There is work to be done to streamline local commissioning and contracting arrangements so that the benefits of locally determined services are not outweighed by the administrative burden. In addition, evidence from early adopter ICBs indicates that even those systems deemed to have the greatest readiness to take on these functions do not have the tools and capabilities they need to carry them out effectively (NHS Confederation 2023). There are particular gaps around access to adequate data on access and service quality, and it was also clear that the most pressing issues facing ICBs relate to dentistry provision, which may leave little capacity to focus on pharmacy transformation. This issue is one reason why our suggested framework allows for a significant amount of nationally specified and priced components, so that progress can be made despite the capacity gaps within local commissioning.

There is value in drawing on learning from other sectors around network management and addressing barriers to exit – for example, investigating the experience of post office and bank closures. This will require national leadership and support in addition to local market management, and NHS England should work closely with Community Pharmacy England to ensure consistent and equitable approaches are adopted across ICSs.

Workforce and training

Actions required

- Pharmacy workforce planning should be fully integrated into the national workforce plan (NHS England).
- ICB workforce strategies should explicitly include community pharmacy alongside the primary care workforce and the wider pharmacy sector workforce (ICS leaders).
- Each ICB should establish a pharmacy workforce board to consider the workforce issues as a whole, including hospital, community and general practice. It should be made up of representatives of hospital, community pharmacy, and pharmacists in general practice. ICBs may need to combine to create this board (ICS leaders).

- ICBs should designate a chief pharmacist (if they have not already done so) whose role includes professional leadership across the different pharmacy sectors (ICS leaders).
- The development of attractive career pathways that support recruitment and retention will likely be linked to the deployment and support of independent prescribing. ICBs will need to work closely with community pharmacy to ensure that commissioned services support their ambitions around workforce (NHS England, ICS leaders).
- There should be a focus on upskilling the existing workforce, ensuring the provision of protected learning time for the whole workforce, and making sure that the system is geared up to manage the cohort of pharmacists who will qualify from 2026 onwards (ICS leaders).

Discussion

The workforce implications of the vision are significant and should not be underestimated. The roles of all those working in community pharmacy are likely to look significantly different in years to come, and those working in the sector need to be prepared for change. Implementing the vision will require changes to skills, capabilities and ways of working among community pharmacists so that they are able to take on the more substantial clinical roles that are envisaged. At the same time, they will also need to prepare for the wider use of pharmacogenomics and precision medicine. Critically, upskilling and development will be required across the wider community pharmacy workforce, including pharmacy technicians (also regulated by the General Pharmaceutical Council), dispensing assistants and others, in order to free up pharmacists' time for delivering clinical services.

Significant changes are already under way to enable pharmacy teams to shift towards more clinically focused roles, including changes to the education and training of both pharmacists (General Pharmaceutical Council 2021) and pharmacy technicians (General Pharmaceutical Council 2017). In 2016, NHS England launched the Pharmacy Integration Programme and from 2023 pharmacist independent prescribing services are being trialled through the selection of 'pathfinder' sites in every region of England (NHS England 2023). There are also many examples of pharmacists taking on enhanced clinical

roles, and pharmacy technician responsibilities are already expanding into traditional pharmacist practice such as medicines reconciliation, accuracy checking and dispensing (Picton *et al* 2022). These and other initiatives offer important opportunities to inform and drive the changes that are needed going forward.

There were strongly divergent views among interviewees around the appropriate level of ambition for independent prescribing in community pharmacy. Most interviewees were positive about the opportunities this presents, but many raised concerns that the sector will not be ready for newly qualified pharmacists to use these skills in practice as soon as 2026. Several interviewees suggested that efforts to transform the workforce were going in the right direction but would not be sufficient to deliver change on the scale or timescales required (particularly in readiness to make use of the skills of newly qualified independent prescribers from 2026). Other interviewees highlighted the need for realism about how long workforce transformation on this scale will take, and the investment and support that will be needed to achieve it.

Interviewees highlighted that service delivery models are still a long way behind where they need to be for independent prescribers to be routinely using their skills in community pharmacy. Concerns were also raised about a lack of supporting infrastructure, including clinical supervisors, access to clinical records, consultation space, and appropriate regulatory and assurance frameworks (discussed later). The NHS England Pathfinder ‘early adopters’ programme offers an opportunity to make progress on many of these issues.

We were told that barriers to developing and upskilling the workforce include a lack of time and headspace for community pharmacists to spend on training and development (particularly for single-handed practitioners), a lack of incentives for private businesses to invest in training and education, and difficulties accessing national and regional training funds, including a perceived lack of transparency over how these are allocated.

A number of interviewees also raised concerns about barriers to those already in the workforce upskilling to qualify as independent prescribers, including a lack of time, funding and supervision to enable this. Health Education England’s most recent Community Pharmacy Workforce Survey indicated that pharmacists with an independent prescribing qualification currently

represent 5 per cent of the full-time equivalent (FTE) pharmacist workforce, equating to approximately one independent prescriber per 10 community pharmacies. However, only around a quarter of these pharmacists reported currently using their prescribing skills within the pharmacy (Seston 2022).

Some interviewees expressed concerns that rolling out independent prescribing more widely would lead to an overall growth in prescribing, with particular concerns around antimicrobial stewardship. However, others strongly disagreed, suggesting that pharmacists may be more cautious than existing prescribers. Interviewees suggested a number of ways to mitigate these perceived risks, including placing limits on the range of drugs that can be prescribed, the use of patient group directions (PGDs), and close monitoring of prescribing data. Again, the pathfinder sites offer an important opportunity to test and learn before wider roll-out. A small number of interviewees also raised specific concerns that community pharmacists would have a financial incentive to prescribe if they continue to also profit from dispensing. A number of contractual and regulatory mechanisms are available to address this risk.

Another consistent theme was the need for multi-professional working. This includes community pharmacists being able to work collaboratively with colleagues in general practice and other community-based services as part of multidisciplinary neighbourhood teams, and to work closely with pharmacists in other settings, including in hospitals and elsewhere in primary care. Interdisciplinary training that starts from the undergraduate stage was suggested as a way of enabling this.

The connections between community pharmacists and clinical pharmacists in primary care employed through ARRS were highlighted as a particular area for development as these roles were often felt to be working in isolation from each other. Some interviewees suggested that ARRS roles should be expanded to include community pharmacists and to fund roles working across both settings.

Many interviewees supported moving gradually towards a more flexible and agile workforce, with pharmacists and pharmacy technicians able to move easily across settings, and with portfolio roles as the norm. It was suggested that this could improve relationships across different parts of the system, as

well as offering more attractive and rounded career options. Questions were raised about the employment models that would be needed to support this, and it was suggested that greater consistency would be needed around salary scales and terms of conditions of employment in different settings. Previous work has recommended the development of a structured post-registration career roadmap for pharmacists and pharmacy technicians, with post-registration curricula and frameworks embedded in multisector training and development pathways, and remuneration and progression linked to the delivery of advanced care and services (Picton *et al* 2022).

A prerequisite for cross-sector roles to work is that there are enough pharmacists overall. Many interviewees were concerned about the impact of the existing ARRS, suggesting that the movement of pharmacists into primary care had left vacancies elsewhere and risked destabilising the community pharmacy workforce. We heard that this is already impacting on the viability of community pharmacies in some areas, and driving an increase in the use of locums, with implications for the cost and quality of services.

Some interviewees suggested that there is a need for a more unified, strategic approach to the whole pharmacy workforce, underpinned by a workforce strategy for the sector. We also heard significant concerns about the wellbeing and morale of the workforce, and in particular the impact that vacancies and financial pressures are putting on community pharmacists, as well as the lack of a clear vision for the future. Addressing these concerns should be a priority for any future strategy on the community pharmacy workforce.

Infrastructure

Actions required

- More work needs to be done to explore the necessary IT solutions. At the minimum an IT system should ensure automated data collection on essential and advanced services from pharmacy systems, as in Wales (NHS England).
- Development of a national approach to community pharmacy IT and a national funding stream to ensure delivery, with investment in software

and potentially transitional support to upgrade hardware in some cases (NHS England).

- A minimum level of access to patient records should be agreed to enable provision of the (primarily acute minor ailment) services under the core national contract, requiring a level of interoperability with GP record systems. More extensive access – with or without associated patient registration – could be trialled in pilot sites offering more advanced services as this will be required for management of long-term conditions (NHS England, ICB chief executive officers).
- ICB estates planning, incorporating community pharmacy, needs to ensure best use of wider public estate in service delivery. This should include mapping the availability and suitability of local estates, and the adaptations or investment required to make these suitable for the delivery of clinical services.
- Consideration should be given to applying the same model for NHS funding of GP premises to community pharmacies, for the space required to deliver clinical services (NHS England/DHSC).

Discussion

The ambitions set out in the vision will require improvements in supporting infrastructure, including changes to the digital tools available and to community pharmacy premises. These were both consistently highlighted as prerequisites for success.

Digital tools and technologies

There was broad consensus that if community pharmacists are to take on a more clinical role, then they will require greater access to patient records than they currently have, and many interviewees stated that they would need both read and write access into electronic patient records. This was highlighted as being essential to ensure the safety and quality of clinical care delivered to patients and the public, and to support continuity with care delivered by other professionals, particularly GPs. In particular, access to patients' full and up-to-date medication records was viewed as essential if independent prescribers are to prescribe safely.

Views varied on whether this could be addressed through simple adaptations to support interoperability between existing systems and giving pharmacists greater access to summary notes, or whether more complex solutions were required to enable more comprehensive integration across different systems. A number of complicating factors were mentioned, including the large number of software systems currently in use and the variety of providers involved.

There was disagreement on whether access should be linked to the existing ‘nominated pharmacy’ approach. Some interviewees felt this could be used as a way of limiting the sharing of records to the patient’s chosen pharmacy, while others felt this would move too far towards a registered patient list and undermine the core characteristics of community pharmacies being accessible on a walk-in basis. We suggest a model where people will still be able to access any pharmacy on a walk-in basis for basic services and simple advice and guidance, but patients would need to consent to the pharmacist being able to access their records to deliver more advanced clinical care.

The Covid-19 vaccine process was an excellent illustration of the potential for better linkage between pharmacies and GP practices. Individuals could choose where to have their vaccine, and vaccination records in primary care were automatically updated.

Ambitions around better access to up-to-date clinical records, and for better linking of information across different care settings, are strongly aligned with wider ambitions across the health and care system to move towards shared electronic patient records. Community pharmacy needs to be part of these wider developments in digital infrastructure.

As well as access to clinical records, some interviewees suggested that it would be helpful for community pharmacies to have access to safeguarding systems and to systems enabling them to refer patients or directly book them into other services. It was also suggested that digital tools could be used to enable better communication with other health care professionals, supporting the development of multidisciplinary working across community pharmacies, general practice and wider local services.

Other opportunities for improved use of digital tools that were mentioned by some interviewees included: automating dispensing processes to release

time and improve safety; more ways to interact with patients and the public, including through remote consultations; and making use of new technologies such as advanced diagnostics and wearables to support disease monitoring and prevention of ill health.

Community pharmacy estates

There was a strong consensus that many pharmacies will require investment and adaptation to their premises to have appropriate consultation spaces in which to conduct more clinical work. Many interviewees highlighted the substantial variation across different pharmacies in terms of their current premises, and the options available for adapting or improving these.

The opportunities and barriers around estates are different for different types of pharmacies – for example, when comparing small independent pharmacies that either own or rent commercial property to chain pharmacies operating from larger retail units.

Several interviewees highlighted specific barriers faced by pharmacies that are tied into long commercial leases, and those where the value of the premises is closely linked to the financial viability of the business. The available options will therefore look very different in different locations and for different types of pharmacies.

Several interviewees highlighted the importance of considering estates in the round, joining up conversations about the locations available for delivery of community-based health and care across local neighbourhoods. In some instances, there may be opportunities for larger community pharmacies with clinic rooms to act as hubs for other community health services, while in others it may be appropriate for community pharmacists to work from GP surgeries, community health service clinics or other locations.

Some interviewees mentioned the possibility for more pharmacies to be co-located with general practice, stating that this could bring benefits in terms of strengthening joint working. However, others strongly disagreed with moving towards greater co-location, citing concerns around the loss of community pharmacies from accessible high-street locations. Some also outlined the high costs associated with leases linked to GP practices.

Regulation

Actions required

- Legislative changes to contract rules to allow dispensing without a pharmacist on site and development of systems that allow safe and accurate dispensing in this scenario. This will level the playing field between dispensing general practice and community pharmacy, and give community pharmacists the opportunity to collaborate with the wider system. It may also offer opportunities to ensure that community pharmacy services can be financially viable in rural areas (Department of Health and Social Care).
- The Department of Health and Social Care, NHS England and pharmacy bodies need to work with the CQC and the General Pharmaceutical Council to develop a more coherent approach to the development of regulatory mechanisms to ensure that the regulatory framework for pharmacy is fit for purpose as the offer develops, particularly mindful of the need for consistency of regulation across primary care for clinical service delivery (Department of Health and Social Care and arm's-length bodies, General Pharmaceutical Council).
- Develop an appropriate understanding of the economics of community pharmacy and to work in partnership with the Competition and Markets Authority to ensure that market management, at both national and local levels, delivers the most efficient use of taxpayers' money in addition to consumer benefit.

Discussion

The pharmacy sector is subject to regulation in relation to both clinical services and commercial/economic factors. There are inherent risks in a rapidly changing sector that regulation and clinical governance will not keep up with developments. As increasingly, clinical services are provided across the primary care sector, variation in the regulatory framework will need to be addressed. Regulators of the community pharmacy sector will need to work closely with other primary care sector regulators in order to ensure a coherent approach to the regulation of clinical services provided across multiple sectors.

The safety and monitoring infrastructure needed to underpin the increased clinical work of pharmacists, particularly independent prescribing, will be critical, and the pathfinder sites will provide useful learning for this. We also heard issues that some current regulations – for example, the need to have a pharmacist on site for dispensing – may be hindering collaboration and innovation, particularly in the efficient development of skill mix in the pharmacy workforce.

In recent years, there has been little attempt to ‘manage’ the market for community pharmacy. In the context of limited resources at both local and national levels, more active market management is required. NHS England will need to take a more active role in the economic regulation of the sector. This will require NHS England to develop a good understanding of the cost structures of community pharmacy across the main types of provider (independent pharmacies and multiples) in order to ensure that pricing and contract decisions do not lead to unintended consequences in terms of market entry and exit, and that at an aggregate level, the funding going into community pharmacy is appropriate to ensure sustainable services.

NHS England will also need to liaise with the Competition and Markets Authority to ensure that appropriate market management – including the ability of pharmacies to collaborate with each other in local systems – is not in conflict with the application of competition law. In particular, ICBs need to be able to take appropriate actions to ensure that the number and location of pharmacies in their areas are both meeting the needs of patients and the public and sustainable within the resources available.

System leadership and integration

Actions required

- The ICB chief pharmacist role should provide clear clinical leadership for pharmacy across the ICB and lead the creation of strong local networks to support streamlined representation of the sector within ICSs (ICS leaders).
- Local Pharmaceutical Committee leads within each ICB should be supported to develop a coherent 'voice' in local planning discussions, engaging with the chief pharmacist (Community Pharmacy England).

- Developing system leadership capabilities within community pharmacy should be a focus, and community pharmacists should be engaged in local leadership development alongside other professional groups (eg, in Surrey 500 and similar initiatives) (ICS leaders).
- There must be recognition that engagement in system working and system leadership needs to be resourced. There should, therefore, be facility within the contract to pay for community pharmacist time specifically for collaboration within primary care networks and at ICB level. Changing the rules around the need for community pharmacists to be physically present to oversee dispensing will also be necessary to facilitate this wider engagement (NHS England).

Discussion

The vision described here cannot be implemented through isolated changes within the community pharmacy sector. It will require changes across the health and care system more widely, particularly across other parts of primary care, to ensure that an enhanced community pharmacy offer is integrated into wider pathways and delivery models.

Many interviewees described the importance of developing a shared vision and understanding across the health and care system about the role of community pharmacy and how this is changing. In particular, it was felt to be important for a shared vision to be agreed within local areas, and for there to be clarity about how this fits with the wider community health and care offer across a local place. The national policy direction has been set out clearly in the Fuller stocktake report and elsewhere, and any changes to community pharmacy will need to form part of the broader shift towards place-based working and neighbourhood delivery models.

Many of those we interviewed described the development of PCNs, and in particular the rapid expansion of clinical pharmacists working within general practice through the ARRS, as having impacted local relationships across primary care and community pharmacy.

Rather than supporting joint working, we heard that these developments had created competition for funding and staff. We also heard that existing efforts

to develop neighbourhood teams often fail to include community pharmacies. Any integration of community pharmacy will also require better joint working across frontline clinical staff, particularly between community pharmacists and GPs.

Interviewees suggested a number of changes that could help to support this, including: better communication routes to support real-time discussion and information sharing, with digital tools to support this; shared clinical information systems; targeted local development work to help build trust and relationships; integrated workforce development, including joint training and portfolio/ rotational roles; and work to resolve disincentives to collaboration such as competition for services, funding and staff (discussed earlier in this report).

To enable the development of an integrated local offer, several interviewees highlighted the importance of different sectors and professionals coming together to develop and redesign patient pathways in the community, and for community pharmacists to be involved in these discussions from the outset. We also heard that it would be important to involve GPs in conversations around the development of new clinical service offers in community pharmacy to ensure that these changes do not disrupt existing service models or fracture care pathways, particularly for management of long-term conditions.

Similar considerations were raised in relation to the future role of community pharmacies in supporting prevention and population health. Interviewees underlined the importance of aligning this with existing local priorities and plans, such as ICS integrated care strategies and local joint health and wellbeing strategies, and with national initiatives such as the Core20PLUS5 approach to health inequalities. Close working relationships with local authority public health teams will be important, both to ensure that local pharmacy commissioning strategies reflect the needs as identified by the Pharmaceutical Needs Assessment, and also to ensure that local authority and NHS commissioning plans are aligned. Indeed, ICSs may wish to develop integrated commissioning strategies for community pharmacy services.

A number of interviewees felt that the introduction of ICSs and local place-based partnerships could help support greater integration of community pharmacy by enabling different partners to come together. They also felt that involving community pharmacists within these arrangements could help to improve understanding of the sector among wider system partners and how it could contribute to addressing local priorities. ICSs and the place-based partnerships within them could also help to provide greater strategic oversight of their local community pharmacy sector and the wider local primary care offer. However, several interviewees raised questions about the capacity and capability within ICSs to do this.

We heard that pharmacy engagement within ICSs is highly variable and remains limited in many areas. Community pharmacy is not routinely represented in the formal governance and membership of ICBs and ICPs. However, it is important to recognise that there is a tension for all ICSs in balancing representation and inclusivity with the need to operate as agile and effective decision-making bodies; community pharmacy is one of many key partners in the health and care system that these considerations would apply to.

Steps that could support better involvement of community pharmacy within ICSs include: supporting Local Pharmaceutical Committees to enable streamlined representation at system level; ensuring that those in ICB chief pharmacist (or similar) roles are engaging with a wide range of colleagues across community pharmacy; and developing system leadership capabilities within the community pharmacy profession.

There should also be consideration of how the voice and expertise of community pharmacy can be represented within relevant ICS workstreams and in the development of specific pathways, and Local Pharmaceutical Committees can play a significant role in co-ordinating this. There is useful learning from research and experience within other sectors facing similar questions about how they engage with ICSs, including the voluntary sector (Gilbert and Ross 2023) and social care providers (Thorstensen-Woll and Bottery 2021).

Implementation support

Actions required

- A step-by-step approach to implementation is likely to be needed, taking account of capacity and capability in both commissioning and community pharmacy (NHS England, Community Pharmacy England).
- Some aspects of the vision will require changes in other parts of the health system as well, particularly (but not limited to) general practice (NHS England).
- Legislative change may be required in relation to regulatory issues such as presence of pharmacists for dispensing (Department of Health and Social Care).
- There needs to be a coherent and consistent voice among community pharmacy representative bodies at national level (Community Pharmacy England).
- For patients and the public to have confidence in the primary care system as a whole, including community pharmacy provision, services need to be coherent, consistent and well communicated (NHS England, Community Pharmacy England).
- NHS England ensure co-ordination of research and evaluation to support development of clinical services, learning from local implementation (NHS England).
- ICBs need sufficient capacity to deliver oversight and support to the community pharmacy sector (NHS England, ICS leaders).

Discussion

The scale of changes needed to deliver the community pharmacy vision will require commitment, capacity and resource at both the national and local levels. The infrastructure needed to provide this support and strategic

oversight for the community pharmacy level is less clear. There was a consensus among those we interviewed that ICBs should focus on how they will develop proactively managed community pharmacy across local places, although less certainty of the capacity within ICBs to do this.

ICBs need access to data to be able to examine variation, and gaps in provision and workforce, together with sufficient analytic support to make sense of that data, using dashboards to identify outliers and to provide systems of support, learning and peer review.

Implementation of changing models to facilitate the move to clinical care may also require external support, particularly for smaller independent pharmacies. Community pharmacies often lack the capacity or skills to easily adapt to new working practices or processes.

Research and evaluation will be key to ensuring that the models of care are appropriate. At present, the general evidence for specific clinical services is relatively sparse (Wright 2016). Evaluation of outcomes and cost-effectiveness should be integral to new services to ensure that any future expansion of clinical services in community pharmacy is built on evidence, both in terms of the delivery models used and the supporting infrastructure required.

Finally, there was a clear view among interviewees that a shared voice for community pharmacy is needed. Those involved in our research suggested that different professional, policy and stakeholder groups in pharmacy holding conflicting positions was not helpful, and that there is a need for greater efforts to ensure a coherent and consistent voice for community pharmacy at the national level.

Financing

Actions required

- Ongoing investment by commissioners in both the revenue and capital and revenue requirement to deliver this vision (NHS England, ICS leaders).

Community pharmacy has experienced a lengthy period of declining real-terms funding, largely driven by the belief that there were efficiencies or profits within the dispensing and supply chain that could help support the rest of the NHS at a time of financial challenge.

In 2023, the NHS in England took the first major step away from this approach by providing additional funds of up to £645 million for community pharmacy over two years. This was to support the extended range of clinical services set out in the delivery plan for recovering access to primary care (NHS England 2023). A similar approach had already been taken in Wales and Scotland, where expanding the role of community pharmacy to provide a wider range of clinical services has come with additional investment. An account of the approach to delivery of community pharmacy services in Scotland and Wales is available alongside this report.

This report has described a future where the range of services provided by community pharmacy will grow and, if successful, will grow significantly. While there may be further efficiencies to be drawn out of the supply chain, and through recycling any resource that can be freed up by workforce changes, delivering this vision is still likely to require increased spending on community pharmacy beyond the investment set out in the primary care recovery plan. This will reflect a number of factors: the enhanced offer to patients and the public; the closer relationship between community pharmacy and the rest of the NHS (some of which will need financial support – eg, for backfill when pharmacists are working with other system leaders); and the need for many pharmacies to invest in their staff and in their estate.

Additional spending in community pharmacy should be seen alongside spending in primary care as a whole. This does not mean attempting to extract from general practice any spending on services now being provided in community pharmacy; primary care in England is experiencing a deep access crisis and for the foreseeable future, there is more than enough patient demand to keep both general practice and community pharmacy busy (indeed, too busy).

Patient and public engagement

Actions required

- An information campaign at both national and local levels to ensure that patients and the public are aware of the services available in local pharmacies and how to access them (NHS England, ICS leaders).
- ICS leaders to ensure ongoing engagement with local communities as new advanced and enhanced services are designed and commissioned, taking a co-production approach and working closely with local VCSE organisations.

Discussion

In developing this vision, we were grateful for the insight provided by National Voices, which had recently held a roundtable sponsored by the National Pharmacy Association exploring the experiences and aspirations of people living with ill health and disability in relation to community pharmacy services (National Voices 2023). It is clear that there is public appetite for accessing a wider range of services in community pharmacies, and that pharmacies have a significant role to play in addressing access issues both for people living with ill health for whom local access is particularly important, and those from minority communities.

As with GP services, there are groups of people for whom continuity of care is particularly important, and the need for pharmacies to build trusting relationships with those people and their carers was emphasised. This takes time, and it is important that both the contractual and funding arrangements for community pharmacy recognise this.

However, although aspects of the vision we describe are already happening in many parts of the country, overall the pattern of community pharmacy provision is somewhat haphazard and ill understood by the general public. If we are to maximise the benefit that can be offered by community pharmacists, and shift pressure from GP services, there will need to be an effective communications campaign to ensure that people understand the growing role of pharmacies and what they can expect from them. This will need to be

delivered at both national and local levels; a national campaign can describe a general scenario, but local activity will be required to bring that to life in each community. This is especially important in areas where the pattern of services varies between pharmacies. Patients and the public need to be signposted to the right place first time, and not ‘bounced’ between care settings unless absolutely essential.

This campaign will need to be carefully positioned to ensure that it is not seen as downgrading the level of service that can be expected; rather, that people will be able to see highly qualified professionals with appropriate expertise in a way that meets their needs and which complements the role of their GP.

ICSs will also want to ensure effective engagement with their local communities to understand their needs and wants in relation to the advanced and enhanced services that they may wish to commission from local pharmacies, and how best to design those services to ensure that they are appropriate for the communities they serve. The importance of strong partnerships with the VCSE and co-production of new services is difficult to understate, if those services are truly to meet both the clinical and cultural needs of patients.

Annex A: Actions, listed by responsible body

Many of the actions set out in this report for NHS England and DHSC will naturally require strong engagement from pharmacy leaders at both local and national level to realise their full benefit, and we anticipate that CPE will address this in their forthcoming strategy.

DHSC/NHS England

Commissioning and contracting

- Set out a timetable for the renegotiation of the community pharmacy contractual framework
- Ensure comprehensive agreement at national level about how community pharmacy fits with the broader primary care strategy, removing some of the zero-sum elements of current approaches where resources are moved between community pharmacy and general practice
- Put in place a focus on building capacity and capability in commissioning at national level, and in ICBs both to negotiate service patterns and to agree contracts
- Support collaboration between community pharmacists, GPs and the wider health and care system: in particular, pilots of services should be locally agreed and test impact across the whole pathway. NHS England will need to take responsibility for evaluating such pilots and for bringing findings together to ensure future contract development.

- Performance measures included in the framework should, where possible, consider patient outcomes as well as activity levels. This is likely to require some piloting to develop.
- Ensure consideration of incentives to facilitate local-level collaboration (eg, payments to free up pharmacy and GP time to come together to identify local issues where working together could deliver value-based care) (NHS England and ICS leaders).
- Develop clear guidance and oversight on conflicts of interest, particularly for the prescribing and dispensing roles and commercial interests (eg, when the evidence goes against provision of medication or other pharmacy items).
- Develop clearer understanding of how to ensure oversight and strategic planning of market entry and exit, both at the national and the local level. Some national market oversight will be required, analogous to the current role of the Care Quality Commission (CQC) in oversight of the care sector.
- Ensure that savings in the sector will be recycled back into community pharmacy to remove disincentives to de-prescribe, or change dispensing intervals.
- Provide investment in IT to ensure that any provider offering advanced or enhanced services has access to the National Care Records Service and additionally to ICB-level shared care records, so that information from pharmacy systems can be shared to those records, and has access to the GP care record where that provides necessary access to information.

Workforce and training

- Pharmacy workforce planning should be fully integrated into the national workforce plan.

Infrastructure

- Support the development of the necessary IT solutions and at a minimum the development of an IT system that can ensure automated data collection on essential and advanced services from pharmacy systems, as in Wales.

- Develop a national approach to community pharmacy IT and a national funding stream to ensure delivery, with investment in software but potentially transitional support to upgrade hardware in some cases.
- Agree a minimum level of access to enable provision of the (primarily acute minor ailment) services under the core national contract, requiring a level of interoperability with GP record systems. More extensive access – with or without associated patient registration – could be trialled in pilot sites offering more advanced services.
- Consideration should be given to applying the same model for NHS funding of GP premises to community pharmacies, for the space required to deliver clinical services

Regulation

- Implement legislative changes to contract rules to allow dispensing without a pharmacist on site and development of systems that allow safe and accurate dispensing in this scenario.
- Working with the Department of Health and Social Care, pharmacy bodies, CQC and General Pharmaceutical Council, develop a more coherent approach to the development of regulatory mechanisms to ensure that the regulatory framework for pharmacy is fit for purpose as the offer develops, particularly mindful of the need for consistency of regulation across primary care for clinical service delivery
- Develop an appropriate understanding of the economics of community pharmacy and to work in partnership with the Competition and Markets Authority to ensure that market management, at both national and local levels, delivers the most efficient use of taxpayers' money in addition to consumer benefit.

System leadership and integration

- Ensure facility within the community pharmacy contract to pay for community pharmacist time specifically for collaboration within primary care networks and at ICB level.

Implementation support

- Develop a communications strategy working in partnership with patient representative bodies which ensures that changes to community pharmacy are seen to be coherent, consistent and well communicated
- Ensure co-ordination of research and evaluation to support development of clinical services, learning from local implementation
- Ensure ICBs have sufficient capacity to deliver oversight and support to the community pharmacy sector.

Financing

- Ensure ongoing investment by commissioners in both the revenue and capital and revenue requirement to deliver this vision.

Patient and public engagement

- Develop an information campaign at national level to ensure that patients and the public are aware of the services available in local pharmacies and how to access them.

ICS leaders

Commissioning and contracting

- Consider incentives to facilitate local-level collaboration (eg, payments to free up pharmacy and GP time to come together to identify local issues where working together could deliver value-based care).
- Agree clear, direct referral pathways where appropriate, together with simple systems for referring between elements of primary care to avoid patients feeling 'bounced' around different elements of the system

Workforce and training

- ICB workforce strategies should explicitly include community pharmacy alongside the primary care workforce and the wider pharmacy sector workforce.
- Each ICB should establish a pharmacy workforce board to consider the workforce issues as a whole, including hospital, community and general practice. It should be made up of representatives of hospital, community pharmacy, and pharmacists in general practice. ICBs may need to combine to create this board.
- ICBs should designate a chief pharmacist (if they have not already done so) whose role includes professional leadership across the different pharmacy sectors.
- The development of attractive career pathways that support recruitment and retention will likely be linked to the deployment and support of independent prescribing. ICBs will need to work closely with community pharmacy to ensure that commissioned services support their ambitions around workforce
- ICBs should focus on upskilling the existing workforce, ensuring protected learning time for the whole workforce and making sure that the system is geared up to manage the cohort of pharmacists who will qualify from 2026 onwards.

Infrastructure

- ICB estates planning, incorporating community pharmacy, needs to ensure best use of wider public estate in service delivery. This should include mapping the availability and suitability of local estates, and the adaptations or investment required to make these suitable for the delivery of clinical services.

System leadership and integration

- The ICB chief pharmacist role should provide clear clinical leadership for pharmacy across the ICB and lead the creation of strong local networks to support streamlined representation of the sector within ICSs
- Developing system leadership capabilities within community pharmacy should be a focus, and community pharmacists should be engaged in local leadership development alongside other professional groups (eg, in Surrey 500 and similar initiatives)

Patient and public engagement

- ICS leaders to ensure ongoing engagement with local communities as new advanced and enhanced services are designed and commissioned, taking a co-production approach and working closely with local VCSE organisations.

Community Pharmacy England

Commissioning and contracting

- Set out a timetable for the renegotiation of the community pharmacy contractual framework
- Focus on building capacity and capability in community pharmacies to collaborate both to negotiate service patterns and to agree contracts.

System leadership and integration

- Local Pharmaceutical Committee leads within each ICB should be supported to develop a coherent 'voice' in local planning discussions, engaging with the chief pharmacist.

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