ROUNDTABLE

The role of pharmacy in the system

To mark the anniversary of Pharmacy First, this roundtable explores the current dynamics between the sector and the wider system

Author: Victoria Vaughan. Front cover image: Getty Images
 First published 2025 by Healthcare Leader Cogora, 1 Giltspur Street, London EC1A 9DD.

HEALTHCARE LEADER

Cogora

Delegates

Hemant Patel
Chief pharmacy officer and director of medicines and clinical policy, NHS Black Country ICB

Jo Loague
Head of service for medicines optimisation and individual funding requests in Arden and Gem CSU

Claire Ellwood
ICB chief pharmacist for Leicestershire and Rutland

Michael Lennox
Integration lead, National Pharmacy Association (NPA) and Andrew Lane, chair of Community Pharmacy Gloucestershire and recent past NPA chair

Victoria Vaughan
Editor of Healthcare Leader

SECTOR CHALLENGES

Victoria Vaughan (VV) What's changed for pharmacy now that ICBs are running the service and what are the current challenges?

Hemant Patel (HP) As a CCG, we were very GP practice-focused and we were a GP member organisation; that changed when we came into an ICB. We've got a wider remit now than we ever did before. NHS England previously had oversight and assurance, which have been delegated to ICBs now. Be it pharmacy, optometry, dentistry (POD) services or trusts, there's a more granular oversight as opposed to the purely primary care performance of before.

Workforce is a key challenge we're all experiencing with not enough workforce and, at the same time, we're having to reduce teams – our trusts are facing that more than any other sector at the moment. Also, in terms of community pharmacy, where a lot of that cohort migrated across to primary care and GP practices, the workforce challenge is immense.

Claire Ellwood (CE) The challenge for me is getting value for money and population health management – how do we address health inequalities and how do we address long-term prevention?

We're really struggling with the fact that we're getting annual budgets, and we've got massive demands on finance, but actually, a lot of the things that we want to be doing are around long-term health prevention, treating long-term conditions, treating things like hypertension lipids, that are going to have a massive impact on population health, but it's not going to be in a year.

How do we prioritise spending money on the things that are going to get us out of our challenges in the longer term when we've got millions of pounds worth of overspend? How do we invest in the right things, and how do we ensure that we reduce health inequalities?

The other one for me is around leadership. How do we come together as a single team for medicine optimisation across the system? We've only got one acute trust of which I'm the ex-chief pharmacist officer and we've got really good engagement there and with the mental health trust and community pharmacy. But what we haven't got is the support for them to get involved in leadership roles within the ICS.

Then we've got an increasingly large workforce, which is probably our biggest single pharmacist workforce, within primary care networks (PCNs) that are not supported to act as leaders in the system space, because there's no funding for them to do that, and it's difficult for them to speak as one voice. For me, there's a real gap around primary care leadership and how we ensure that pharmacy is part of primary care collaboratives and has a voice in what happens within the ICS.

PCN pharmacists are doing what is required of them by their PCN clinical directors, versus actually utilising that resource to work together across the system for medicines optimisation. For me, that's the change we need in order to achieve the kind of left shift within Darzi, because there's huge potential. But we've got a lot of people in PCNs in pharmacy who are not being supported to be leaders and to operate at top of license. If you compare how their skill sets are being used versus how they would be used in hospital, there's no comparison.

VV Is it your role in the ICB to try and facilitate that leadership or should it be coming from somewhere else?

CE It's part of my role to look at how we maximise the benefit of pharmacy staff across the ICS. As for how we fund opportunities for PCN pharmacists to be involved in leadership, I can try to do that, but actually, there are things that could be done nationally through additional roles reimbursement scheme (ARRS), for example, which would facilitate that.

VV Jo, as you work with multiple ICBs in this space, what's your take on their role in this?

Jo Loague (JL) Yes, what Claire was saying really resonated with me. One of the issues that we see when you've got new people transitioning into a brand new sector is whether there is support there so they can do that safely. If we look at the shift of meds management from CCG days to now, the support was really good. We had a really clear training plan that was standardised across all practice pharmacists at that point, whereas now, because it is quite diluted, it varies.

The other challenge is that we often get asked to deliver things at pace. It might be because it's a key priority or because of the way the funding works because we do work in isolated financial years, and they need to spend some thinking within the financial year, and that can be a challenge. And I think there's something about trying to facilitate that things are done well, not just quickly.

Also, it's thinking about how you add in the capacity and the capability within those teams across the interfaces. That's really important.

> Let's be optimistic. Student numbers are up. Four new schools of pharmacy are opening. Never before will there be so many students pumping out over the next four or five years… How do we harness that revolution…?
>
> Michael Lennox

COMMUNITY PHARMACY

VV Andrew and Michael, how do you see the ICB role in pharmacy and what would you like to see from them?

Michael Lennox (ML) Community pharmacy is better cradled by having the ICS revolution. I think 42 ICSs is way better than what we had before in the context of likely patient care and population health.

It has been challenging for meds optimisation and medicines management in this restructure and move to integrated care systems. Broadly, ICSs have lost a heck of a lot of personnel across their medicines management function – part of the 30% cut. I saw that up and down the South West, with really good operatives being cut back. If you look at places like Somerset and Cornwall, I believe there are now very few that are doing active meds optimisation and meds management work.

That being said, we've moved to a delegated contract. We've moved to having pharmacy in a golden thread within the additional roles reimbursement scheme (ARRS). We've got the whole thing about the delivery of pharmaceutical care and pathways all up for grabs.

The two or three key things from a community pharmacy perspective is that we're operating in an old-generation contract at the minute. Our contract is just broken, and it's not helping patient care, pharmaceutical care, delivery of meds optimisation and patient safety. It is a functional contract that's inadequately funded and needs to be completely reimagined and re-engineered, taking our role as it is now into what we can do and what can be optimised, right here, right now.

Secondly, we're facing a workforce revolution. As tough as it is at the minute and as depleted as historical sectors have been made by the ARRS roles, there's a bounce back happening. Let's be optimistic. Student numbers are up. Four new schools of pharmacy are opening. Never before will there be so many students pumping out over the next four or five years, right? And we've got the tech revolution, and in community pharmacy, we've got the independent prescribing revolution.

How do we harness that revolution and make a manifest difference to pharmaceutical care? In the NPA, I'm working with colleagues in the Company Chemists' Association and we have framed what we think the future might look like in a couple of research papers. We think the future is strengthening that golden thread of pharmaceutical care, with community pharmacy being a thicker part of the thread than it has been historically. I applaud pharmacy being in general practice, but we need to connect it back in and optimise what it does in community pharmacy. Actually, 40 years in, I feel we could be on the cusp of manufacturing a new golden age of pharmaceutical care if we optimise the role of community pharmacy in it.

VV How can ICBs harness these opportunities?

CE The key thing is getting community pharmacy seen as a strong partner within primary care. We talk about Primary Care Collaboratives being the future, but actually, in most systems, they are GP collaboratives. For me, it's how do we bring the community pharmacy into that space? If we're designing services outside of hospital, what should be led by a GP, what should be actually done by community pharmacy, and probably what needs to be done by them both working together in some kind of mid-service between primary care?

It's about breaking down those traditional frictions between GPs and community pharmacies over things like vaccines. We've got community pharmacists working as PCN engagement leads within each of our PCNs. We're only a couple of months into that, but that's really showing some positivity in terms of breaking down some of those barriers and building some of those relationships.

We're starting to see the impact in things like the hypertension service and Pharmacy First and increasing referrals. But for me, we need to do more building relationships at the neighborhood level, demonstrating the kind of mutual benefit. We've got a PCN that's completely stopped doing any work around contraception, full stop, because it's all being done by community pharmacy. And that's been a real positive development between the community pharmacy and the GP practices.

This year, we're going to be working with local authorities to review the pharmacy needs analysis (PNA) for both Leicestershire, Rutland and Leicester City. We're really keen that it shows where the need is to expand clinical pharmacists for community clinical services because that was last done three years ago, and it's a very, very different landscape now. There's a real opportunity there to get in that document where we see the gaps and the need for service expansion.

HP The overarching point is that pharmacy is in a really good place in terms of its reputation which has ramped up since Covid. We're pushing an open door for a lot of these things. And when we talk about the collaborative, the ambition of the system community pharmacy is in the middle of that, and it wasn't previously.

The other element is the move, especially within primary care, away from competition to collaboration, and we're at the beginning of this. We can also see a vision where migration from

> Deprescribing is a massive opportunity. You know, we've got volumes going through the roof. Independent pharmacy and community pharmacy generally can't cope with the volumes that have been coming at us
>
> Andrew Lane

community pharmacy to GP practices in terms of professionals may be going the other way. If we can harness the Independent Prescribing Pathfinder programme and similar commissioned services in the future, there are likely to be more services being managed in community pharmacies rather than GP practice settings.

Currently, many individuals working in GP practices may find themselves in roles that lack a clear strategic vision within some PCNs and local systems. Rather than being integrated into a well-defined workforce plan, they are often assigned tasks based on what the PCN or clinical director perceives as immediately useful. This can lead to highly skilled professionals being underutilised—spending time on discharge summaries or prescription requests instead of working to their full potential. This misalignment is concerning, as it risks not only disengagement but also higher attrition rates, with individuals potentially leaving not just their roles, but the profession entirely.

The other bit is burnout. There's a lack of motivation in those roles. Part of my role is almost championing pharmacy – community pharmacy, pharmacy professionals, including technicians – and articulating what's possible, showcasing good examples. Being that conduit in the ICB, in the exec arena, right through to those on the ground in terms of employment of pharmacy professionals.

Also, quite a lot of that time is about engaging with community pharmacy and GP practices, seeing what the issues are and getting past those. There's lots of examples where some of the solutions are very simple. It's just that both parties haven't really understood each other's viewpoints and pressure points. And when we get those individuals around a table, quite often, the solutions are there and quite easy to see. That's why we've seen that massive increase in Pharmacy First and in the hypertension case finding through community pharmacy.

PHARMACY FIRST

VV What do you think about Pharmacy First and how ICBs have supported the roll-out over the last year?

Andrew Lane (AL) It's all about collaboration. The interesting thing for me, as chair of Community Pharmacy Gloucestershire, I've had a very close relationship with a lot of the senior execs on the ICB before they became ICB senior execs, and that helps because you do business with people you know. Community pharmacy has needed to be better at infiltrating the people it's going to be working with in the future, the people it has probably worked with in the past, but at arm's length because the doctors held it all within their little tent.

In terms of how we develop the relationships further with the ICB, Pharmacy First is our unique opportunity to go to the ICB with a business case and data. There's now lots of data around how Pharmacy First is cash-releasing in the system. Certainly, in Gloucestershire, the senior executives were 100% [saying] 'we can't wait to implement Pharmacy First. We can't wait to get involved in some of the mechanics. How do we convince the doctors to make more referrals?' So, having that collaborative approach with everybody in the same tent discussing the journey to solutions, particularly around communities. As Claire described, it's a population health strategy that we've got to build into here, and all global governments have the same issue. The cost of health systems is getting greater.

What we're not doing is making our business case at system level and including things like Pharmacy First as part of that business case and building on the fact that we are really trusted by the public. That's one of the things that came across really strongly at a recent OECD meeting I was at. We are massively trusted, particularly around things like vaccination. And it was a surprise to me that anti-vax globally is a massive problem. And interestingly, if we're to improve our public health persona, then that vaccination space is ours to dominate and just helping people through that journey as a trusted partner in the vaccination process is a massive win for future health systems.

Deprescribing is a massive opportunity. You know, we've got volumes going through the roof. Independent pharmacy and community pharmacy generally can't cope with the volumes that have been coming at us, and that will only increase. We've got to have strategies that look at deprescribing and how we can impact ICBs' cost positions because, obviously, that's been one of the key themes that has just been mentioned by our colleagues on the ICBs. Everyone's looking at the in-year cost. We can make big inroads. Pharmacy First is just part of that journey, but it's a really good way of starting off conversations if they're not already happening.

VV Do you get the sense that ICBs are on board with managing both current pressures and population health for the future?

JL As individuals, people are absolutely behind this. But the challenge is when they're being monitored against in-year finances that overrules that priority, and so it becomes practically difficult for the ICB to do anything else other than think about that. We've been talking about this for years, and we've still not got the bottom of it, and I don't know why. The other thing around the funding side is that ICBs have been given funding for

> People are absolutely behind this. But the challenge is when they're being monitored against in-year finances that overrules that priority, and so it becomes practically difficult for the ICB to do anything else other than think about that
>
> Jo Loague

the community pharmacy clinical lead (CPCL) posts, but not all ICBs use that.

I don't know what it's like for Claire and Hemant, but you've got that funding for that role yet they still have to go through other hoops as well. There's something for the ICB being practical as well. We need to release that post because we know those CPCL roles have been really pivotal in helping implement that change. We've been able to have that role, and it has worked. That mutual ground to say, 'I understand your challenges. Let's try and work together through this', rather than that constant battle. Michael, you've mentioned the community pharmacy contract – that is a massive issue and something that we hear, 'We can't do that because it impacts our funding'. At the end of the day, they've got to pay the bills. How do you overcome that?

VV In terms of population health, how do you look at your area and work with other people in the ICB to plan for that and develop your pharmacy workforce?

CE Population health management is not about pharmacy. Pharmacy is not going to solve this alone; it's about how we work with other teams within the ICB and ICS to address the issues we've got. Take something like weight management, which is absolutely massive at the moment. That's not a pharmacy problem to solve, but pharmacy is a massive contributor to how we address weight management. It needs a partnership with local authorities, various teams within the ICS, and specialist weight management services.

There are a couple of things where pharmacy really adds value. Sometimes it's about actually looking at the issues where we are not doing what we could be. It's looking at the data. There's very rich data within pharmacy and within prescribing. How can we get more value from the investment we're putting in long-term conditions and longer-term health? And that is where we can bring in the innovation of taking stuff out of hospital, using community pharmacy. But how you create the budgets for it is incredibly difficult.

We have just committed to putting a lot of money into renal and chronic kidney disease prevention because we've demonstrated that it has a payback in terms of the reduction of patients moving on to dialysis. But it's been a lot of work to get to that point. We're putting patients at risk of worsening chronic kidney disease on additional treatment that is actually going to cost more money but is going to give a payback in the longer term, and we've made that argument because we're able to demonstrate, from the evidence, why this is the right thing to do.

It's thinking about where is the payback going to be? And this is very much in line with the Darzi-type stuff because we've demonstrated through a pilot that actually we're having fewer referrals to secondary care specialists because they are supporting the PCN in upskilling to identify these patients and intervene earlier. But it comes at a cost because we've increased the drug spend in that area.

I think part of our role is recognising where we are not spending enough money. We're not spending enough money in optimising hypertension because we've not identified the patients who would benefit. It's not always trying to find efficiencies and reduce costs, it's about saying what we're getting value from.

The key role within medicines is how we reduce the spend on medicines that are inappropriate in order to invest in the things that are of higher value. We've been working really closely with finance in the last couple of years…The best thing is when you go to a meeting and finance tell you why we should be spending more money on a drug. And once you've got them telling you that, I think that's really positive.

VV How are community hospital and PCN pharmacists going to be involved in neighbourhood health as mentioned in Darzi?

HP The neighbourhood thing probably happens in certain places better than others, I would say. It's where you've got that level of maturity in place. So that requires individuals to think much more holistically, as opposed to their organisational boundaries that they've been logged to previously. The other bit is that much of this investment requirement is at a time when most systems are in chronic deficit, and so it's very difficult to argue the case where it's not truly a cash-releasing investment. Cost-to-save schemes are fine within a year; when we are talking about things like CKD and others that are likely to require longer-term investment for the gains to be realised, that's more challenging when you've got pressure from the centre on most ICBs in terms of their deficit position. We've got to get over this deficit position before we really can do the work that we want to do around prevention as opposed to the firefighting we're having to do at the moment.

FUTURE DEVELOPMENTS

VV How can pharmacy in the system be best used for the future sustainability of the NHS?

ML Collectively within the pharmacy family, we need to make those cases about return on investment. We're so frequently seen as a cost base. I had breakfast with Paul Corrigan from the Department of Health and Social Care, who's leading at a

> Coming together as pharmacy professionals across the system makes a massive difference in what we can achieve. We've seen huge shifts in that since covid and building on that is critical.
>
> Claire Ellwood

ministerial level on the 10-year plan work for [health secretary] Wes Streeting, and Paul was very clear: 'There ain't no new money'. We've got to shift money out of hospital. We cannot just keep getting sicker as a country with more people needing tertiary intervention. It can be done by leveraging the hospital slightly to uplift primary care.

But if we don't get a new contract bloody quickly that puts fresh money on the table and changes the mechanics by which community pharmacy uses that money so we can get the right resources and do stuff differently, we will not be able to face into this new mode of action and the new missions that come.

We need to get tech to take the strain on some stuff in terms of our processes in community pharmacy and dispensing, but also the production of prescriptions.

Electronic Repeat Dispensing (eRD) is a laughable process now. It can be made to work like a steam engine can be made to pull a train, but it is not the right way in the 21st century to flow reviewed meds towards a patient.

And then the Pharmaceutical Needs Assessments (PNAs) really need to reimagine [what's possible] for pharmaceutical care and how community pharmacy supports what's happening in general practice. We haven't optimised discharge medicine services. It's beyond patchy and yet one of the most lifesaving, money-saving services that likely exists in the world of pharmaceutical care.

We really haven't optimised Pharmacy First either yet, because we're reliant on referrals. The only bit of Pharmacy First that's growing is the stuff that we are allowed to do in terms of finding patients in our own practices. The GP referrals are going down at the minute.

JL It's about having that common goal, that common agenda, where everyone genuinely understands each other's pressures and tries to facilitate for each other. There's got to be some out-of-the-box thinking. I don't know what that looks like, because the funding will be the funding whenever that's confirmed.

And it's ensuring that new prescribers are safe and making sure that the existing workforce is fit for purpose because we've got a lot of power in the workforce. We have some really clever people with some great skills.

AL As I said a bit earlier, the focus needs to be on collaboration, collaboration, collaboration. Where there is good practice with community pharmacy engagement, why wouldn't you replicate that in other ICBs? And I don't think we share cross borders as well as we could. We know there are pockets of good practice. We know some ICBs are really heavily engaged with their community pharmacy networks. We just need to spread that word and ensure that we facilitate that more within the NHS. We just need to come together around a common business plan, cash release that can get back into the system. And systems, like Michael said, will see the value of that five-to-one ratio.

HP Reflecting back on years gone, there was lots of infighting within the pharmacy profession. The sectors were at loggerheads previously. I think that's gone now and that is really refreshing. We've come together as a sort of pharmacy family over the past few years. Now, I don't think that's happened in other professions, and we know that. I won't go into that now, but I can see that we're not particularly good at selling our wares and the good stuff we do. Ultimately, it comes down to [the fact that] there's lots of historical practice. We're not going to undo all of that, but if we keep the patient at the centre of these decisions and we truly think about a value-based proposition or value-based decision-making, we often are going to get to the right decision.

CE It's probably about silos, professional leadership and innovation. We've done a lot with this already, but it's about breaking down the professional silos between different sectors and really making sure that we particularly support pharmacy within the primary care sector to have a loud voice.

Coming together as pharmacy professionals across the system makes a massive difference in what we can achieve. We've seen huge shifts in that since covid and building on that is critical. The other part of silos, though, is that I absolutely think that medicines optimisation is not a pharmacy task. It's wider than pharmacy. We need to be linking with the other professionals. We need to be linking in with managers and programme support within the ICBs.

There's a risk that we go into a little professional silo. It's got to be about making medicine optimisation part of wider work within the ICS. That's utterly critical. And I think part of that is about us being professional leaders within that space, outside our own profession as well, and clinical leaders.

And I guess the final bit is around the innovation. We've touched on it a little bit, but for me, there isn't going to be a huge amount of new money. There's a massive amount of things we need to do in terms of a sicker population, pressure on money, pressure on resources, and if we just carry on trying to deliver services in the way that we are, we're not going to change anything. We're not going to improve healthcare. So, for me, it's absolutely about taking some risks, addressing innovation and trying different ways of delivering services because, you know, just carrying on is going to break our staff, and it's not going to deliver the care that we need to be doing.