



THE PHARMACIST
ROUND TABLE



**TAKE ME TO YOUR
PHARMACY LEADER**
HOW TO GET STRONG SECTOR
REPRESENTATION

How can pharmacists make their value impossible to ignore - and secure the support and funding the profession deserves?

In this roundtable, five pharmacy leaders join editor Victoria Vaughan to explore the power of strong pharmacy leadership, how to elevate grassroots voices, and what the sector can learn from other professions. This event is in support of our Community Pharmacy and General Practice conference.

● THE PANEL

Danny Bartlett

Clinical lead for primary care workforce and senior lecturer at the University of Brighton

Dr Graham Stretch

President of the Primary Care Pharmacy Association

Shilpa Shah

CEO of Community Pharmacy North East London

Shveta Suri

Head of pharmacy productivity at Derby and Derbyshire integrated care board

Sukhi Basra

Vice-chair of the National Pharmacy Association

● INFLUENCE AND IMPACT

Victoria: How can pharmacy leadership further the profession?

Danny Strong leadership needs to be outcomes-based.

We know our value, but we need to prove it in the language that resonates with other professions. I think quite often we expect to get noticed and for the work we do to be seen by other clinicians. But often it isn't because we haven't changed the language or adapted our message to reach the people that we need to.

So, when we're talking about primary care and integrated neighbourhood teams, [we need to think about] what's the integrated neighbourhood team's priority? Is it reducing hospital admissions? Then, how can we do that? How can we use the objective of the integrated neighbourhood team to bring pharmacy into that discussion?

So, it's about aligning your narrative and language with the integrated neighbourhood team's priorities. It's not coming with, 'Why is pharmacy not there?' It's coming with, 'We can hear what your priorities are. We agree. We can help with this specific part'.

Clinicians generally are quite rubbish at writing business cases – that's a very big generalisation, but I've seen very many poor ones. I think we need to say: 'Look, I know my population and what they need. We've tried it in a small pilot and this is what we've achieved. And if you give us funding – if you give us the resourcing – we can do that.'

Graham Good leadership is demonstrating the art of the possible.

[An example would be], back in 2010, we built teams to do care home prescribing in a much more structured way and that led to the commissioning of training for care home pharmacists. We then had about 20 GP practices where we were managing all of their prescribing.

Then, we got to about 2015, and the RCGP basically said, 'We've got this massive recruitment problem for GPs. We need some help with this'. And NHS England was looking at other healthcare professionals – pharmacists, physios, social prescribers and paramedics – with an idea that we could work in general practice. And many of us already were.

So, then there's a pilot – first it was 50, then it was 450, and then, through several waves of funding with an associated training package that got them all up

to a baseline level, it ended up being about 1,800 pharmacists.

That then facilitated ARRS in the 2019 inception of primary care networks and the idea that primary care should be a multidisciplinary team. At that time, there were about 1,800 pharmacists; there are now more than 11,000 pharmacy professionals working in general practice in England alone.

Danny I was one of the first ARRS pharmacists. I think ARRS started on 1 July 2019 and my first day was 3 July. At the start, ARRS was like Woolworths' pick 'n' mix, where a PCN might put their hand up and say, 'I'll have one of everything'.

So, everyone had to find their own way. I had to build a team around me and move into that space, but it was a space that didn't necessarily exist in every practice or PCN. If they hadn't had a pharmacist or a pharmacy technician before, you had to prove your worth a bit.

One of the things that I hopefully brought in my own leadership journey was being a bit more accountable for my own follow-ups and showing value in terms of following a patient journey.

Shilpa As CEO of Community Pharmacy North East London, my main role is about being a leader for 370 pharmacies across seven boroughs and being the voice for community pharmacy within the ICB and the London region. We've had some really good buy-in from our ICB to get funding for various projects that we want to do in community pharmacy.

I've used my leadership [skills] to lead my team and pharmacy teams across North East London to deliver on these various services we've been able to innovate, develop and get commissioned. We're involved right from the inception, which I think is really important.

But it's taken time to get to that level. You need to be able to get that trust, to get that buy-in. And as a leader, you need to do what you say you'll do. That's really important to build that trust.



Good leadership is demonstrating the art of the possible
Graham Stretch

Sukhi I think, as a sector, we have a personality that's too humble. We don't know how to articulate our value and, if we can't articulate it, there is no data to show and if there's no data to show then, in leadership, how do we prove that we are valuable?

So, how do we provide a clearer picture of what we bring to the table? What is the return on investment of having pharmacists in the mix? They are already there. They are the linchpin of a lot of things.

We need to be a little bit prouder and we need to learn how to quantify what we do that isn't quantified. I'm very proud, but I think one of the things I need to work on is helping the rest of the sector feel that they are a really valuable member of primary care.

Graham If we don't get these integrated neighbourhood teams right, we'll once again find pharmacy being excluded and we mustn't allow that to happen. We need strong central leadership, but it needs to be devolved. The people who have an opportunity to sit at that table need to sharpen their elbows and make it absolutely clear that you cannot have a neighbourhood team by excluding the one healthcare professional who works with an open door in that neighbourhood – and of course, that's the community pharmacist.

So, that's the challenge for us at the moment. And that's one of the major pieces of work that we'll be looking to the Royal College of Pharmacy to lead – to influence and to advocate to make sure that pharmacists play their key role in those integrated neighbourhood teams. If we don't do that, we're missing a huge opportunity.

I don't care whether you're an ophthalmological pharmacist, a renal pharmacist, whether you work in general practice, or whether you're a community pharmacist; that college needs to feel like your home, and you need to feel that it's working for you.

● LEADERSHIP AT ICBS

Victoria: What do you think pharmacist leadership within the ICB looks like? How do you ensure your voice is heard?

Danny It's not an either-or with general practice, and there's a lot of that kind of narrative. Both can coexist. I always come back to there being 19 million people with two or more chronic conditions in the UK at the moment, and by 2049, there's going to be 35 million. There's enough work to go around. I don't think we need to be fighting over who's doing what.

Graham What we don't really have, I feel, is leadership that's visible enough for the employed and local pharmacists and community pharmacists. That's something we all need to look at improving.

I was in a meeting about neighbourhoods and, on the very first slide, pharmacy was described as a service profession. And naturally, my hand went straight up to say that we aren't a service profession. I'm not suggesting for a moment that supply isn't the very foundation of our profession, but actually, we're very much more than that.

We need parity of esteem with the medics and the nurses and the other professions. We are autonomous professionals. We provide care directly to people who come into community pharmacy, directly from the street. We hold that risk.

Shilpa Community pharmacy needs to change the culture. We need to be more inclusive of everyone within community pharmacy. It's not just about pharmacists. It's about pharmacy technicians, healthcare advisors, dispensers, locum pharmacists – everyone working in our team.



SEAN ANTHONY EDDY / E+ / VIA GETTY IMAGES



Leadership should never depend on what your role is. It's behavioural

Shveta Suri

We've got to really develop that inclusivity and diversity in our teams, and then we need to open that up further.

We've been fighting for years to be recognised as part of primary care with, you know, GPs taking the forefront, and we need to be part of that. One of the things I do now is make sure I involve optometry and dentistry in every conversation, so they're not in the same situation I was maybe five years ago. I think we need to be doing a lot more of that.

Graham A crucial part of the 10-year plan is that we need to be moving care wherever we can, as far left as we can, into those organisations that are closest to patients in their communities – and we know who that is. If we manage to do that, then we really will see an explosion in influence. But we're at a pivotal point in that journey.

There are some things that should be our unique selling point. We can demonstrate it with vaccinations. I think vaccinations may well prove to be the thing that demonstrates that community pharmacies can provide these services in an efficient, convenient way for patients.

Look at the poor uptake of things like MMR and childhood vaccinations – why can we not commission our community pharmacists to do that? It's so convenient for mum or dad to take their child to a community pharmacy.

And if they can do vaccinations, why aren't they doing hypertension, and why aren't we making sure our heart failure patients are getting all the medicines that they need, and so on? Let's build upon the foundations that something like vaccination provides.

Shveta My reflection is that leadership is not positional, particularly in an ICB setting. It should never depend

on what your role is – it's behavioural.

What I'm experiencing, particularly now that we know our teams are getting smaller, is that we have to be more agile. We have to influence in a smarter way; leadership has to be behavioural and, in some ways, it has to exist at every level.

Sukhi You don't necessarily have to be the loudest voice to be the most influential. Your influence might be because you saw someone who's of value and you put them in the right place.

Good leadership means being humble enough to recognise leadership in others who perhaps don't see it in themselves. You become a leader by quietly nudging people along with you. I was nudged and I think you can pay that forward. It means you don't end up being the leader on your own.

Shilpa What I do feel sometimes is that you can be in a room full of people where your voice isn't heard. I think it also goes back to being a female leader in pharmacy – and I don't know if Sukhi will attest to this – but sometimes there are voices that are often a bit louder or something will be said in a different way.

It's one of the skills you don't often get taught on a leadership course, but it's about tone of voice and how to be assertive as a leader. That's something I learned along the way. It doesn't need to be aggressive or bossy.

And, actually, we all have a responsibility to make sure the next generation coming up to be leaders are helped with that specific skill.

● GRASSROOTS EMPOWERMENT

Victoria: You mentioned being a female leader. What should grassroots female pharmacists be thinking about when it comes to leadership roles? And, regardless of gender, how do we empower all grassroots pharmacists to step up?

Sukhi The majority of us in the sector – 60% of us – are



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So, I'm going to speak to those young ladies out there and say, 'I was you'. I was that individual pharmacist who didn't think leadership was a role for me. It needed another woman to nudge me and say, 'Go and apply. Go and do it'.

So, I'd say [to grassroots pharmacists]: 'Taste new things and be curious. If you don't like it, you can change your mind, but at least you can think that you gave it a go. If you are meant to be there, you'll stay there.'

It's about empowering the next generation and telling them they are really valuable. I'd like to say to everybody who's not in a leadership role that one of the most valuable and important parts is the face-to-face with patients. You may think it is of little value, but having that experience is what leadership at the table really needs.

When I come to the table, it's almost like a declaration of interest. I am the smallest linchpin compared to lots of the big guns sitting at these tables, and I'm really proud that I am just a meagre community pharmacist. I'm a small-but-mighty community pharmacist who works in the community every day.

Shveta I'd say be comfortable being uncomfortable. And I'd also say something that my dad has always said to me – adversity is the best teacher. If something goes wrong, we can probably learn from it.

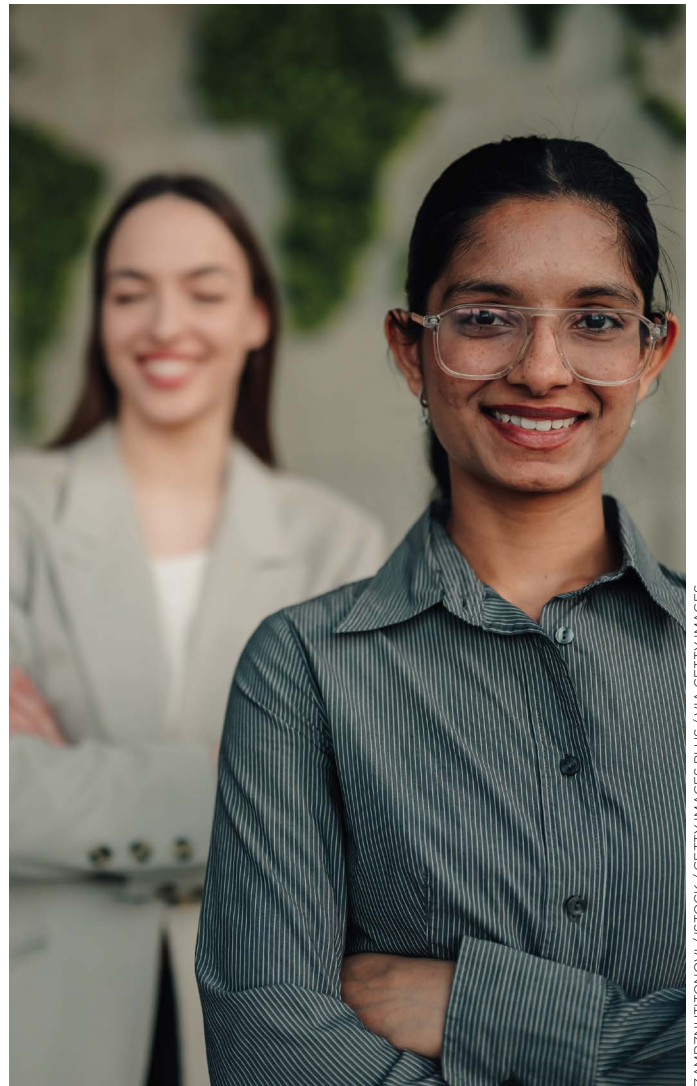
One of the key challenges I experienced earlier in my career was that I didn't realise what I was capable of doing. It took a couple of colleagues to tell me, 'Shiv, you've done that before. You don't realise. You are doing quality improvement and improving your KPIs, you just don't know it'. So, it's about having that behavioural leadership around us as a profession.

And thinking about the ICB setting, where we know the teams are getting smaller and you've got fewer people to do a lot more – for me as a leader, there's no need for me to feel like I need to work harder and become overwhelmed. I need to be busy with my own team. And I've got a responsibility to spot where this opportunity that's coming towards me could be given to somebody who's looking for that opportunity. There are real legs there to grow people into those leadership roles, if those roles are right for them.

Danny [My advice is to] observe a meeting before you go for a role on a board. It's so important to know what you're getting yourself into.

And if you want to go for a leadership position, it's vital that you shadow that particular role. Not everyone's going to open their doors to you, but it's always worth an ask.

And don't expect people to reflect on your gaps for you. You've got to reflect on that yourself. You've got to



think, 'What do I do well and what am I not so strong in? And what roles appeal to me?'

We're really rubbish at reflecting. Again, it's a big generalisation, but clinicians are generally rubbish at reflecting on their own skills gaps – and [even] what they like – because they're not given the time to do it.

Excuse the pun, but we are very prescriptive. We wait for people to tell us what we're good at and what we're not good at, what we've passed and what we've failed. The biggest thing for me is just giving people the space to reflect.

Graham We're asking how grassroots and early-years pharmacists can get involved in leadership. Actually, let's turn this whole thing on its head.

My current foundation trainees will be the first to qualify as prescribers. We've given them a toolkit and I actually think it's for us – me, the older guys in the room – to make sure that they get to use those hard-won skills that we've given them.

We need to develop roles and pathways to facilitate their journeys. And if we do that – and if we are leaving the door open, giving them that hand up – what we'll see is that the profession will develop in ways none of us can anticipate.

We need to give them that platform and the skills needed, and we need to support them. And they will develop their own roles.

Shilpa It needs to start at university. Obviously, the syllabus is clinical and it's about talking to patients. But where is the leadership training? Where is the coaching and that kind of development as well?

And it's looking at community pharmacy during that trainee pharmacist year as well. I think that was the year when I was probably pushed the most in my career by my pre-reg tutor, who saw that I was probably a bit more into leadership than into clinical. And whilst I had an exam to pass – and so I had to do all of that work – he would give me lots of leadership opportunities to do things around the branch where I worked.

It was, you know, managing the rota, managing payroll, going to disciplinary meetings, etc. It was all about learning. He was on the LPC, so I'd go along with him to LPC meetings as an observer. And I'd go to the GP practices when they were having meetings etc.

So it's about giving students every opportunity. There are so many great leaders across the patch and, actually, every community pharmacy owner is a leader of their own business. It's really about pushing, stretching and developing people out of their comfort zone.

● LESSONS FROM OTHER PROFESSIONS

Victoria: Are there leadership lessons from other professions? Have you seen leadership examples that pharmacy should adopt – or avoid?

Shilpa What GPs do really well in leadership is that they stick together. They have one voice. When I'm in ICB meetings, I see that there are GPs from different boroughs there, but they all stick together in their messaging. I think we're getting better at doing that in community pharmacy, but I think we've still got a long way to go.

In pharmacy, there is still that sector divide – you know, I work in hospital, I work in community, I work in a GP practice, I work in a prison. So, we need to get one voice and be inclusive of every sector speaking together. I'm hoping that the Royal College of Pharmacy will do that because they are representing everybody.

We also need to bring in our other counterparts because, actually, I see doctors at the forefront and I don't see the people behind them. I don't see pharmacists who work in GP practices at many of these meetings and I don't see practice managers either. It is the GP that you see.

This is where pharmacists have a real opportunity to shift thinking. I think Sukhi said it earlier, that we're very humble in community pharmacy. We need to lose that. It's okay to have a small amount of pride in what we do and to show it off a bit more.



We're very humble in community pharmacy. We need to lose that
Shilpa Shah

Graham The rise in the number of pharmacists working in general practice has served us well in terms of recognition for our profession. Now, medics are quite used to working with pharmacists in primary care, in a way they weren't previously. I think that really helped to facilitate this idea that pharmacists, regardless of where their setting is, can contribute to patient care. And I hope that we can capitalise on that.

We need to see more of community pharmacy representatives. If I look at the LMCs, they have strong organisations and, as Shilpa mentions, our medical colleagues stick together.

I remember right at the start of the PCN journey, I presented at London-wide LMCs on why they all needed a pharmacist in their practices. Nobody's arguing with that now – that's been done. So, let's have that same conversation about what community pharmacy needs.

Why can the PCNs not provide a laptop to all of their community pharmacists? Why can they not be their DPP? Because what happened with PCNs is that they became GP networks, not primary care networks.

Danny I'll start with the bad, which is that you can't start from a polarising viewpoint because you're just going to disenchant your membership, the profession and everyone surrounding you. And quite often in the media, there's an either-this-or-that narrative, which isn't the right way to lead. You need to bring people with you.

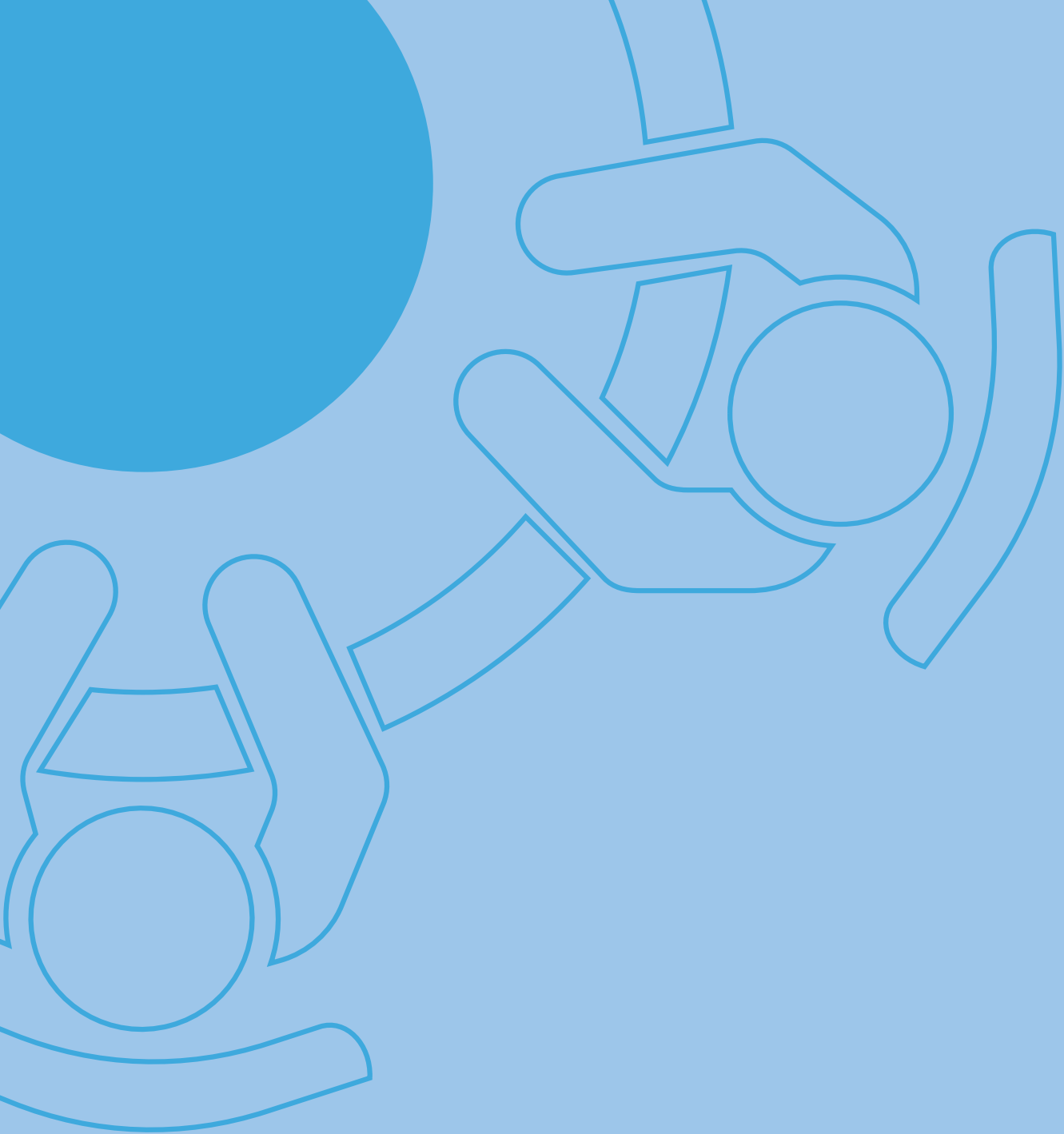
There's also something about the form and function of the roles that people need to move in those spaces. If we're to have leaders with a variety of different experiences, job planning is going to be vital.

When I think about good leaders from other professions, they've been given the freedom and the concessions in their job planning, and perhaps their salary, to do that. That doesn't exist for many other professions. I think medics have got it really right with that.

So, if we look at things like consultant medics, they have really effective job planning. They might be clinical for two days a week, have an educational role one day a week, and on other days, have a leadership ICB function. We don't have that in pharmacy as much.

And until I'm blue in the face, I will be saying this: we need consultant posts in primary care, because how are you expecting system leaders and pharmacy leaders to be at those tables if you're not giving them the time and space to free themselves up to do that? We need to build the structures that help people aim towards those types of posts.

You're not going to have 900 of them in an ICB, but if you have two or three really good pharmacist consultants per ICB in a primary care sense, imagine how many doors they're unlocking. Imagine how many rooms they'll be able to go into.



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Cogora Limited, 1 Giltspur St, London EC1A 9DD, UK

T +44 (0)20 7214 0500

F +44 (0)20 7214 0501

E xxxxx@cogora.com

W cogora.com

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