PM Healthcare
PROGRESS THROUGH PARTNERSHIP

Q&A panel questions

The Future for Pharmacy in the New Restructured NHS in England - What we know and the opportunity to lead on medicines use

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Pharmacy has often been inward-focused & found it challenging to establish a strong presence in NHS leadership and strategic discussions. How do we address this?

For too long we've described ourselves to each other, not to the system. The way through is to stop asking for a "seat" and start bringing a plan. If we show how medicines optimisation contributes directly to things like waiting list reduction, avoidable admissions or financial control, people listen. In my Substack I've written about MO as a strategic function, not just governance or compliance. When we talk in system language, build alliances with finance, public health, acute CMOs, we move from being observers to being indispensable.

Collaboration and the strength of the collective voice is key: how do we blur the line between "ICB/ providers to join up conversation and change culture?

I don't think we should be blurring the lines. ICBs are commissioners and providers are providers. It's up to commissioners to understand their population and inform providers what they want from them, and then step back and let them get on with it. There isn't enough resource in the system to allow for that overlap to continue. Culture however does need to change, but I think that it more between providers (and across the primary/secondary care interface).

What about prevention? Is this not a core issue to address?

Prevention isn't a side project, its core business. Medicines are prevention—statins, SGLT2s, GLP-1s, vaccines—if we use them well. And community pharmacy can make prevention tangible: testing, titrating, nudging. But only if outcomes are commissioned and measured. If an ICB pays for QRISK reduction or HbA1c at target, prevention becomes everyone's day job.

What role or function do you see hospital pharmacy has in the 10YP?

Honestly I think they are going to be challenged. Is there really a need for a huge team of clinical pharmacists and pharmacy technicians and support staff focussing on in-patient stay, medicines reconciliation etc when it has relatively little impact on someone's overall health and outcomes? Would that same clinical resource be more valuable based in a community or neighbourhood delivering the sorts of services that will change someone's overall life chances and wellbeing? We need to keep people safe in hospital, but far more valuable is keeping people out of hospital.

Pharmaceutical industries are pulling money out of the UK and the NHS struggles to access new medicines which is very concerning. What are your thoughts on this?

This is where the relationship has to grow up. The NHS can't treat industry as a tap we turn on and off, and industry can't treat NHS as just a sales channel. What we need is predictable, transparent frameworks—real-world pilots, rapid data capture, and honest timelines on NICE and uptake. I've written before that transactional sales rep models don't serve either side. Strategic partnerships on outcomes do.

What practical steps can pharmacy take to change the delivery model - how do you get a seat at the table or what tools could enable this?

Bring something concrete. A costed pathway, a stop-list of what to disinvest in, and a simple implementation plan. People fund certainty. A one-page logic model and a 12-week sprint plan gets you listened to. This is what I meant when I wrote about MO being strategic: we earn our place by making change easier for others to deliver.

Five years ago we didn't have anything as impactful as the Pharmacy First national services. What will be the new services in the next five years?

If Pharmacy First was about access to acute care, the next wave will be about chronic disease control. Think hypertension detection to treatment, inhaler optimisation, weight-management medicines with digital support, antimicrobial stewardship with point-of-care testing, and structured post-discharge follow-up at home. These are high-volume, high-impact, and play to pharmacy's accessibility.

Is funding available to try new pathways? The message we keep getting is the money is the money which stops innovation and long-term benefits.

The money is the money, but there is always money if you can make a good enough case. Real terms cost reducing will always be easiest to sell, but moving into population health I expect that to change.

A lot of fluffy corporate 'strategic' language in the 10YP. How do we clearly and simply explain these changes to our staff who will need to operationalise this?

All leaders need to understand the complex, and make it simple. Don't worry about translating too much of it, frame it as being 'what will change about the job I do every day' and take it from there.

Does the panel think that community pharmacy-based IPs would be more effective focusing on prevention and minor illness rather than long term conditions?

No, I think LTCs and prevention.

Are there plans to develop a national guidance about working collaboratively with pharma?

Yes, the ICB Chief Pharmacist network is looking at doing this.

At the minute, a lot of time is spent on relations between providers and primary care e.g. shared care. How do we build when foundations are weak?

The relationship between acute and mental health providers and primary care is fundamental to the development of neighbourhood health and the successful delivery of the NHS Long Term Plan. When foundations are weak, it is essential to foster collaborative working, ensuring that providers work together more effectively and seamlessly, always placing the patient at the centre of care. The planning framework encourages NHS organisations, local authorities, social care providers, and the voluntary sector to work together to design and deliver neighbourhood health services. Developing robust Neighbourhood Health Plans will help clarify roles, responsibilities, and shared outcomes, providing a stronger foundation for integrated care.

References:

NHS England — London » A neighbourhood health service for London NHS England » Planning framework for the NHS in England

How can we give ourselves an identity when patients recognise GPs and nurses and pharmacy is often left out. Community pharmacists are often seen as shopkeepers.

Pharmacy as a profession needs to be more vocal and confident about its achievements. Although pharmacists often do great work that goes unrecognised, there are positive signs of change. The creation of the Royal College of Pharmacy and the development of a national vision for a modern community pharmacy will help raise the profile of the profession. Community pharmacy's strong track record in administering vaccines, delivering blood pressure checks, and providing clinical services is already changing public perception, but there is a need for more proactive communication and public relations to ensure that the value of pharmacy is widely understood.

Is now an opportunity to explore mutual training and working of Pharmacy Professionals e.g. hybrid model within primary care and secondary care?

I strongly support the idea of mutual training and hybrid working models for pharmacy professionals. Mandatory cross-sector (multi-sector) rotations will be required for all trainees starting in the 2027/28 training year and are already in place in many areas across the county. Exploring shared posts or hybrid models—where pharmacy professionals work across primary and secondary care—will strengthen workforce flexibility, skill mix, and patient care continuity. For example in SEL we have shared roles between the ICB and providers and PCNs which are hugely successful in bringing greater understanding to the issues across interfaces of care.

How do we move from commissioning activity, which often builds in perverse incentives counter to holistic needs, to commissioning for better outcomes?

In implementing strategic commissioning we will need to move from activity-based to outcomes-based commissioning. Ideas for this include :

- Align incentives with holistic patient needs, not just service volume.
- Use robust data to measure and reward improvements in patient outcomes. A great step forward is to use national datasets such as those used by open prescribing to drive quality improvement and assess outcomes.
- Foster collaboration across sectors to deliver integrated, person-centred care.

How do we balance NHS need for affordable medicines with the Government ambitions to make UK viable for Health sciences industry and pharma?

Balancing the NHS's need for affordable medicines with the government's ambition to make the UK a viable location for the health sciences industry and pharmaceutical sector is a complex challenge. Part of this will be a better relationship and engagement of ICBs and providers with NICE regarding system readiness and affordability. The national medicines value and access team and procurement experts have a key role in exploring and implementing transparent, value-based pricing agreements. ICBs do have a role in supporting innovation while ensuring access and sustainability - collaborative working with industry to align NHS and economic goals would be a way forward.

How do you see AI and technology affecting the pharmacy profession and how can we begin to prepare?

Artificial intelligence and technology are already making an impact and are set to transform the pharmacy profession. They will automate routine tasks, freeing up pharmacists to focus on clinical care, for example dispensing robots and AI systems.

AI will also enable better data analysis for population health and personalised medicine. Preparing for this transformation means investing in digital skills, infrastructure, and effective change management now which can be challenging in the current financial climate. This is especially true for community pharmacy colleagues to commit investment where the NHS services are variable or dependant on others (eg GP referrals).

Commissioning for outcomes sounds great but how do you balance short term cost pressures vs longer term outcomes?

Balancing short-term cost pressures with longer-term outcomes requires a shift in mindset and commissioning frameworks to reward prevention and long-term value. Pilots and business cases that demonstrate the return on investment for upstream interventions are important, as is strong leadership to champion long-term thinking.

The NHS has recently shifted from an annual planning process to a multi-year planning approach. Under the new Planning Framework published in September 2025, NHS England is moving towards a rolling five-year planning horizon. This change is designed to support more thoughtful, long-term strategic planning and to break the cycle of annual funding settlements and planning cycles, which have previously made it difficult to focus on transformation and sustainability.

Idea - NHS owned community pharmacies to supplement the privately owned enterprises. Never been done up to now. So what's the blocker to it?

The concept of NHS-owned community pharmacies is novel and has not been implemented to date. Barriers include legislative, financial, and operational challenges, as well as the need to ensure that any new provision complements rather than competes with existing community pharmacy services.

Value of medicines to also include society impact sounds spot on - how do we build the evidence base for this, and also monitor impact?

To build the evidence base for the societal value of medicines, it is important to use real-world data and health economic analysis, partner with academia and public health, and monitor impact through longitudinal studies and patient outcomes. It would be important to use outcomes which matter to people to capture this, such as enabling people to return to work.

How can the pharmacy-led national vaccine model be applied to smoking cessation and weight management to achieve a smoke-free Britain and reduce inequalities?

The pharmacy-led national vaccine model was nationally commissioned, whereas smoking cessation and weight management are locally commissioned by Public Health and councils. Local commissioners can leverage the accessibility and trust that community pharmacy enjoys, integrating these services with local public health and primary care pathways, and using data to target and evaluate interventions.

Why such a focus on LTCs in community pharmacy IP when prevention and minor illness are huge opportunities to make an impact and reduce pressure elsewhere?

While long-term conditions are a priority for community pharmacy independent prescribing, prevention and minor illness management are also significant opportunities which are commissioned in many areas. Expanding the scope of independent prescribing to include these areas can reduce pressure elsewhere in the system and maximise the impact of pharmacy.

On Single national formulary-What process or criteria will be established for decommissioning or removing medicines from the Single National Formulary?

We are expecting national communications on the development of the SNF in the near future.

What levers are in place to influence the price of drugs?

A key mechanism is the Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG), which caps NHS spending on branded medicines and requires pharmaceutical companies to pay back a percentage of sales if spending exceeds the cap. This helps ensure medicines remain affordable while supporting access and innovation. In addition to the VPAG, other levers include national procurement and negotiation, value-based pricing frameworks, health technology assessments (such as those conducted by NICE), and managed entry agreements.

We're probably moving towards spending another £5 billion on weight loss medication. How can we ensure value from that spend in the context of the 10YP?

To ensure value from spending on weight loss medication, interventions should be targeted to those most likely to benefit (as set out in the interim commissioning guidance from NHS England), outcomes should be monitored and commissioning adjusted accordingly, and these medicines should be integrated with broader lifestyle and prevention programmes. Ongoing monitoring of patient outcomes, including weight loss achieved, improvements in comorbidities, and quality of life, should be built into commissioning and service delivery. There is a challenge in collecting this data nationally within the NHS provision to enable a data-driven approach, real-time evaluation and adjustment of prescribing practices to ensure that the medicines are delivering meaningful benefits.

Secondary care finds it hard to access the PCN networks. What work is being done to make it easier. How do we improve communication both way?

The NHS Planning Framework 2025 emphasises the need for integrated, multi-year planning across all parts of the health system, including primary and secondary care. Improving access between secondary care and Primary Care Networks (PCNs) is a key part of this approach. The framework encourages local leaders to develop credible, integrated five-year plans that join up strategic and operational planning across organisational boundaries. This includes strengthening communication channels, developing shared digital platforms, and supporting joint workforce planning between secondary care and PCNs. By embedding these principles, the NHS aims to break down barriers, improve collaboration, and ensure that patients experience more seamless care across the system.

How can the change happen to look more closely at value and outcomes for patients and not drug acquisition cost ?

Some thoughts on outcomes have already been provided. Data should be used to demonstrate value beyond acquisition cost, and clinicians and patients should be engaged in value-based decision-making.

On specialised commissioning : What is going to happen to the delegation of services and medicines budget to ICBs in 2026-27?

In line with the planning framework, ICBs will have responsibility for a number of commissioning areas from NHS England, including some specialised commissioning functions. This will replace previous plans or delegation arrangements. ICBs have been asked to set up Offices of Pan ICB Commissioning to enact these responsibilities and further details are awaited.

With the increased number of job cuts how are you incentiving future pharmacits to join ICB/ICS' mission as to just joining pharma?

To incentivise future pharmacists to join ICBs and Integrated Care Systems (ICSs), it is important to highlight opportunities for leadership, innovation, and system-wide impact, offer clear career pathways and development, and foster a culture of inclusion, support, and professional growth.

Medical workforce still have some anxieties around non-medical prescribers. How do we breakdown those barriers given pharmacists with prescribing certificate?

To address anxieties among the medical workforce regarding non-medical prescribers, it is important to provide robust training and supervision for pharmacist prescribers, promote interprofessional education and collaboration, and share evidence of safety, effectiveness, and patient benefit.

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