PM Healthcare
PROGRESS THROUGH PARTNERSHIP

JOURNAL

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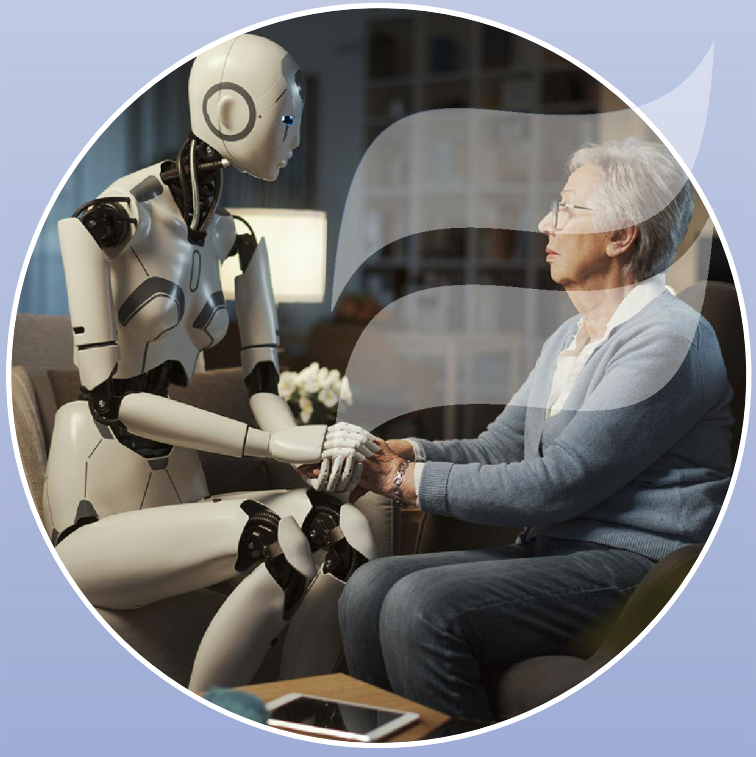

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- Updates on PM Healthcare events, webinars and activity
- The latest developments in all pharmacy sectors
- ICS and ICB developments
- Issues affecting medicines optimisation and the supply of medicines
- The sharing of ideas and viewpoints on healthcare
- Best practice and shared expertise

Do you have an idea for an article or an area that you think we ought to be covering in the Journal?

If you have an idea for an article that you would like to discuss then please get in touch to see if we can include it in the Journal.

We are very keen to support healthcare professional who want to write about:

- Their experiences working in pharmacy and the related professions
- Examples of best practice
- Ideas and innovations that have improved patient care
- Clinical studies and papers that are of interest to a HCP audience, with a focus on pharmacy
- ICS/ICB-led initiatives in pharmacy, medicines optimisation and management
- System changes and reforms that have improved patient care locally and are capable of being scaled up
- Career development stories that will inspire the next generation of pharmacy graduates
- Opinions and commentary from those delivering services

These are just a few of the areas that are of interest to our readers and that contribute to our objective of bringing you insightful and relevant content that translates into best practice and practical application.

Please contact me with ideas at:

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Editorial

We do live interesting times. As if we do not have enough challenges to contend with in healthcare at the domestic level, we must now struggle with a potential international crisis not just in energy supply but also in the many other areas of life that will potentially be affected.

Jim Mackey, the head of NHS England, has expressed concerns about a potential shortage of supplies such as syringes, masks and surgical instruments caused by disruption in international shipping. This is against a backdrop of the UK importing the majority of its drugs and many medtech items. It is of course not possible to say for how long Iran's blockade of the Strait of Hormuz will continue, or the wider effect of the disruption caused on other supply lines.

For this, our Spring issue of the Journal, we focus on matters at home relevant to pharmacy and wider healthcare.

David Tamby Rajah provides a timely follow-up to his 2025 PM Healthcare Journal article about successful community pharmacy integration in the Celtic nations – this time with insights and learning from an international perspective.

Two AI and technology experts – Stephen Goundrey-Smith, Ethics and Technology Specialist, SGS PharmaSolutions, and Asif Mukhtar, Consultant Pharmacist and Founder & CEO of PharmBot AI – provide expert analysis of the current state of play in the ever-evolving world of AI and its impact on pharmacy.

Aarti Patel, Pharmacy Lead – Transformation, describes how a sustainable medicines cost improvement and transformation programme can become a cornerstone of sustainable transformation in medicines management.

Janki Patel, Lead Pharmacist Specialist Medicine and Medicines Value, gives us practical strategies for delivering sustainable NHS savings in high-cost medicines.

Rachael Lemon, trauma specialist and founder of Lemon Aid Coaching & Consulting, shares her personal experiences and asks how pharmacy can implement and improve systems to recognise the signs of trauma and promote a supportive working environment.

As ever, our objective is to provide you with insights that translate into examples of best practice and real-world experience. If you have an idea for an article that you would like to share, then please get in touch.

Link to the latest Journal here: https://www.pmhealthcare.co.uk/journals/ and to our new blog here: https://www.pmhealthcare.co.uk/blog/

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Pharmacy First Update – What changes need to be embedded to achieve Pharmacy Forward?

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Introduction

Last year, in 2025, I had the privilege of writing an article on Pharmacy First - **Achievements of Community Pharmacy Integration in the Celtic nations – What are the lessons for England to move from Pharmacy First to Pharmacy Forward?**[1] Feedback was provided from the UK Celtic nation community pharmacy negotiators and pharmacy leaders in England to see what the English Pharmacy First Model could learn. The UK Celtic nations, namely Scotland, Wales and Northern Ireland, have embedded community pharmacy more deeply into primary care through sustained investment, broader clinical pathways, and clearer integration frameworks. This year's article follows on from this.

In 2026 the question is no longer whether community pharmacy can deliver clinical services at scale — it demonstrably can. The question now is strategic: how does England move from *Pharmacy First to Pharmacy Forward?*

This update looks to the combined views of the national community pharmacy trade bodies, the Company Chemist Association (CCA), Independent Pharmacies Association (IPA) and the National Pharmacy Association (NPA).

International community pharmacy exemplars such as Nova Scotia and Queensland demonstrate how prescribing, governance and system redesign can unlock transformational change in the community pharmacy o[er. This article also examines two models from England where Pharmacy First referrals have been improved. These innovations from England and abroad would integrate community pharmacy further within neighbourhood health and integrated neighbourhood teams where the NHS is heading.

> **"Perhaps a re-engineering and restructuring of the Community Pharmacy Contractual Framework (CPCF) to support primary care recovery, such as the elective care recovery programme, is the way forward. This could restructure funding, IT integration and workforce development allocated to community pharmacy. Revised outcomes and system metrics could evidence pharmacy integration and how this could be measured in practice."**

I am very grateful to the Company Chemist Association, Independent Pharmacies Association, the National Pharmacy Association, Community Pharmacy Cornwall, Community Pharmacy North of Tyne, Queensland Guild of Pharmacists and

Pharmacy Association of Nova Scotia for sharing their views and best practice. This article pulls together the sector views, international examples and NHS direction, to help England move from Pharmacy First to Pharmacy Forward.

1. Activity Growth 2025–2026: A Service Gaining Momentum

From my last article, there were early concerns identified in 2024 for Pharmacy First centred on low referral volumes and threshold pressures. By 2025–2026, activity has strengthened significantly.

- Monthly consultation volumes have increased steadily since launch.
- ICB variation remains pronounced — with some systems delivering more than five times the activity of others.
- Self-referral pathways are becoming increasingly important where local commissioners have enabled them.
- Seasonal surges (ENT, UTI, shingles) show clear demand elasticity.
- Emergency contraception has been added to the national pharmacy contraception service.
- Pharmacy Technicians can now supply medication under patient group direction.

The public can go directly to a community pharmacy to receive treatment and advice for the seven conditions. This was delivered rapidly in 2024. The increased service trajectory demonstrates public appetite for this convenient service. However, activity growth has been uneven and dependent on:

- GP referral behaviour.
- Local system leadership.
- IT integration maturity.
- A community pharmacy workforce going through rapid clinical transformational change gaining confidence in PGD-based pathways and independent prescribing.

The risk now is that Pharmacy First has reached a plateau with only seven conditions, and no further spread of the service by other health systems beyond general practice referral i.e. minor illness clinics and the front door of emergency departments in hospitals. The service needs not only clinical expansion as seen in the UK Celtic nations, as well as Queensland and Nova Scotia, but also structural reform and re-engineering addressing contractual investment, workforce development and IT infrastructure development.

2. The Sector's Voice: Organisational Perspectives

The three community pharmacy trade bodies were approached for comment and kindly provided their views and recommendations for Pharmacy First.

2.1 The Company Chemists' Association (CCA)

The CCA has strongly supported the service, noting that Pharmacy First has been a success with consistent year-on-year growth.[2] It is supported through strong relationships between general practice and community pharmacy. The CCA supports the service for the following reasons:

- Increased access and convenience. It provides a walk-in access point for urgent care in communities, improving convenience for patients.
- Relieves pressure on general practice. Evidence shows Pharmacy First can reduce GP workload. The current model could free up millions of GP appointments annually, and expanded versions could multiply this benefit significantly.
- Positive impact on health inequalities. Around 27% of consultations have been in the most deprived communities, helping reach underserved populations.
- High completion within pharmacy. Many patients (over 90%) have their care completed in pharmacy without onward referral.

The CCA has identified the following issues with the Pharmacy First service:

- Public awareness of Pharmacy First remains limited, reducing potential patient uptake.
- Referral utilisation is low, with very few consultations originating from GP or NHS 111 referrals, meaning integrated patient pathways are underused.
- Regional variation, engagement and delivery vary significantly by NHS England region, leading to uneven service provision. The service appears to be performing better in locations where previous minor ailments services existed, and where Pharmacy First is supported through strong relationships between general practice and community pharmacy.
- Operational challenges are faced in local engagement between pharmacies, GP practices, ICB teams, and broader system partners need strengthening to embed Pharmacy First effectively.

The service has not yet reached its full potential and could be strengthened through the following:

- Expanding the number of conditions and eligibility criteria to increase patient volume.
- Addressing funding erosion and inflationary pressures.
- A much broader promotion of the service to raise public awareness to ensure people think Pharmacy First.
- Workforce burnout and pharmacy closures.
- To truly unlock the service's potential independent prescribing skills must also be added to existing pathways.[3]
- The current 'minor illness' element of Pharmacy First should become a 'walk-in' service, rather than relying on NHS 111 referrals, mirroring Pharmacy First and the Common Ailments Service in Scotland and Wales respectively.
- Support implementation and use local performance data to support conversations with practices and patients, increasing referrals and collaboration.

CCA modelling shows that a fully expanded service could free up to 40 million GP appointments annually.[2]

In summary, the CCA views Pharmacy First as a success that must be strengthened, properly funded, standardise service uptake nationally, and expand conditions to unlock its full potential for patients and the NHS. With

expansion, community pharmacy could become the first port of call for routine primary care, enabling GPs to focus on more complex cases.

2.2 The National Pharmacy Association (NPA)

The NPA has strongly supported and publicly welcomed Pharmacy First as a convenient, safe and effective route for patients to access care and an important part of evolving neighbourhood health services. They emphasise collaboration with general practice and primary care colleagues to improve local care pathways.

The NPA highlights the following strengths of Pharmacy First:

- Improved patient access. Pharmacy First is seen as a practical way to o[er same-day care for minor conditions, helping patients avoid unnecessary GP appointments.
- System efficiency. The NPA highlights its role in reducing pressure on primary care, fitting the broader NHS strategy to shift appropriate demand to pharmacies.
- Broader community pharmacy role. NPA backs the service as a springboard for expanded clinical activity (e.g., prescribing, other advanced services) in community pharmacy.

The NPA's consistent message: Pharmacy First must not be delivered on fragile infrastructure without adequate funding and support. The NPA has advised pharmacies to consider limiting services or hours, illustrating the risk to capacity if financial pressures persist. The NPA stresses that expanded clinical work (including Pharmacy First) must be funded in addition to, not at the expense of, baseline medicines supply and dispensing funding.

The key concerns of the NPA were:

- Funding and financial uncertainty through funding erosion, inflationary pressures, the timing of clawbacks and unpredictable remuneration.
- Workforce limitations and pharmacy closures.
- The mismatch between service expansion and core contract sustainability.
- Operational barriers around delayed or withheld payments.

The NPA listed the following solutions to Pharmacy First, which include:

- Adequate and sustainable funding. Above-inflation funding settlement for 2026/27 to cover rising costs and bridge the sector's funding gap.
- Funding must explicitly support expanded clinical services (like Pharmacy First) alongside core dispensing functions, not as trade-offs.
- Pharmacy contract reform, to give pharmacies greater certainty, fairness and clarity (e.g., reduce clawbacks and unpredictable funding).
- Embed clinical services, fund independent prescribing and clinical roles across community pharmacy as part of the national commissioning framework.
- Strengthen NHS operational delivery to address payment system issues (including timely payment of Pharmacy First activity) and ensure robust integration with NHS systems.
- Workforce and support. Ensure pharmacists are integrated into clinical governance discussions and care pathways locally.
- Quality monitoring to include Pharmacy First outcomes in local evaluation frameworks to assess impact on access and primary care demand.
- Collaborative primary care integration to support relationships with general practice and other primary care partners to ensure smooth referral pathways and shared care delivery.

The NPA argues that a properly supported Pharmacy First service—appropriately scaled, clearly scoped and widely implemented—would enable a substantial 'left shift ' in

patient pathways. This would help general practice manage the transfer of activity from secondary care envisaged in the 10 Year Plan, while supporting integrated neighbourhood primary care working.

The need to bring together the frontline of general practice and community pharmacy provider networks has now been taken forward by the NPA, who be launching their integrated primary care conference for pharmacy and general practice colleagues in June. This will enable at scale the sharing of collaborative practice successes, setting a more positive mood and mode for the two professions to build new models of care and working.

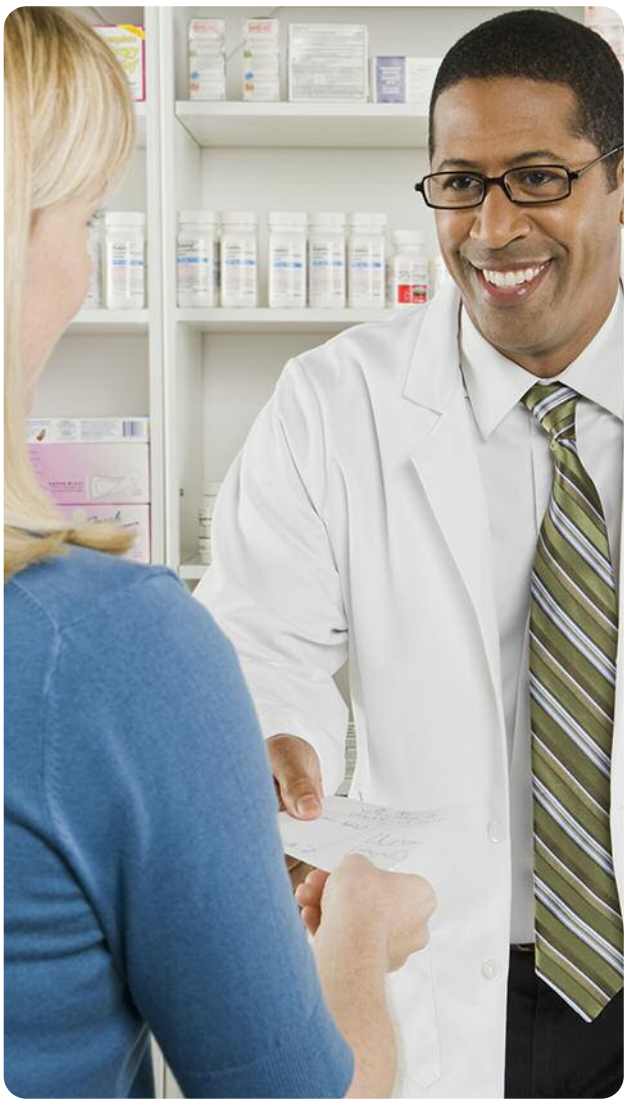
2.3 The Independent Pharmacies Association (IPA)

The Independent Pharmacies Association (IPA) is supportive in principle of Pharmacy First as a strategic shift toward greater clinical utilisation of community pharmacy. The IPA noted that patient feedback has been overwhelmingly positive, with Healthwatch England reporting that the vast majority of patients have had a great experience using Pharmacy First.

The IPA would like the following for the Pharmacy First service:

- Clinical recognition and formal commissioning of clinical pathways enhance the professional status of independent pharmacies. This moves the sector beyond a dispensing-only model.
- Improved patient accessibility through community pharmacies which are highly accessible without appointments. The service has potential to improve speed of access for minor illness and common conditions.[5]
- System relief in primary care through the appropriate redirection of activity from GP practices and urgent care. This is an opportunity to support ICB system efficiency goals.

There are still some issues and concerns that need to be addressed:



- An over-reliance on GP referrals where the IPA argues the service is overly dependent on GP referrals in practice.
- Reduced direct patient access if referral flows are inconsistent.
- Variability in GP engagement across areas.
- Lower-than-expected activity where referral pathways are weak.
- Financial sustainability where the IPA highlights an insufficient core funding settlement for community pharmacy.
- Rising operating costs (workforce, national insurance, business rates).
- Lack of immediate financial injection to stabilise contractors through insufficient core funding.
- Risk that pharmacies cannot sustain increased clinical workload.

- From an ICB perspective, IPA signals that capacity risk is linked to financial fragility.

Delivery at scale concerns which include:

- Workforce pressures.
- Administrative burden.
- Risk of service inconsistency between independents and larger multiples.

The IPA recommendations for Pharmacy First changes include:

- Pharmacy First needs to be a pull service rather than a push service for it to be a bigger success. A shift towards self-referral, and a reduced dependency on GP referrals.[6]
- Promote Pharmacy First as a walk-in, patient-initiated service.
- Strengthen public awareness campaigns.
- Expand the service scope and pathways with more conditions and prescribing flexibility.
- Align Pharmacy First with wider urgent care redesign.
- Provide funding certainty through funding stabilisation, multi-year settlement that recognises inflationary pressures.
- Strengthen system integration through improved digital interoperability, better local GP pharmacy engagement frameworks and clearer ICB-level implementation support.

The IPA firmly believes that the service will be more successful if patients are empowered to access the service directly when they need it rather than being dependent on GP referrals. This must be underpinned by continually improving public awareness.

The CCA, IPA and NPA have articulated the need for adequate funding, the introduction of independent prescribing, service expansion to match the UK Celtic nations, and less dependency on GP referrals to self-referral. This feedback from the three trade bodies is a very compelling call for change.

3 Case studies in England and Abroad

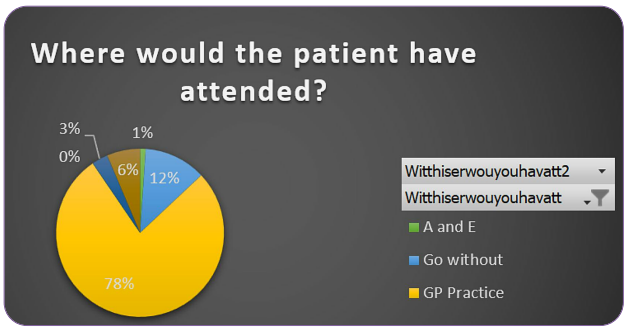
This article researched innovative models in England and from abroad.

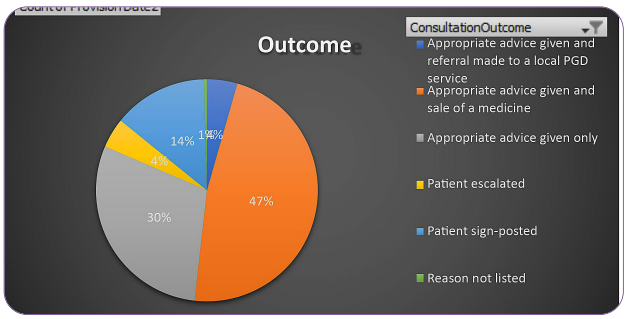
3.1 Case Study: Community Pharmacy Cornwall – Walk-In Consultation Service (WIC)

Cornwall offers a compelling model of local enhancement that complements Pharmacy First.

The Community Pharmacy Walk-in Consultation Service (CP WICS 2) operates alongside Pharmacy First and enables structured face-to-face pharmacist consultations for minor illness, including self-referral walk-in consultation service. Key features:

- 15,000 additional structured consultations commissioned locally by the Walk-in Consultation Service.
- £14 professional fee per consultation Walk-in Consultation Service.
- Consultations delivered in private consultation rooms.
- Clear red flag referral pathways.
- Mandatory use of PharmOutcomes for documentation.





Crucially, Cornwall addressed a major national weakness: dependency on GP referral volumes. By commissioning self-referral capacity locally, Cornwall reduced pressure on GP triage and increased pharmacy activity.

The Cornwall Walk-in Service demonstrated the 'shift left' philosophy with just over 75% of patients questioned who stated they would have gone to the GP if there were no local commissioned service. The service outcomes showed:

- 47% of patients were given appropriate advice and a sale of an over-the-counter medicine.
- 30% of patients were given appropriate advice only.
- 6% of patients were given appropriate advice and referral to a PGD service.
- 14% of patients were signposted.
- 4% of patients were escalated.

Lesson for England: Local commissioning flexibility enhances national framework services and can complement Pharmacy First.

3.2 Community Pharmacy North of Tyne – Best for Per Capita Uptake

This part of England often reports very high consultation rates per pharmacy. The approach taken by the local pharmaceutical committee (LPC) was to explore the other non-GP referral routes into Pharmacy First. The LPC put resources to work with GP practices to improve referral of eligible patients; however, this proved challenging.

The ICB funded coaching team was set up to specifically target and support GP practices with everything Pharmacy First related, from initiating the service and setting out local agreements between GP practice/community pharmacies to troubleshooting IT issues and coaching administrative and clinical GP staff on how, when and why to refer eligible patients into the pharmacy service. The coaching then linked with their respective community pharmacist primary care network

(PCN) leads to promote communication across the system with LPC funded evening networking events.

The coaching team also generated a practice Pharmacy First guide outlining and summarising key inclusion/exclusion factors for referring patients. This handy one-page guide which the LPC funded to print and laminate is still a key successful outcome win from this work and has been adopted in the current work the LPC is collaborating on with a National Care Navigation Training provider.

The LPC focused on the following pathways to raise awareness:

- In schools, the targeting of parents of primary school-aged children and their support networks to empower them to know where to go for minor illness/ailment treatment to get better access to services.
- The parents of secondary aged children were engaged through evening meetings with parents and teachers.
- College and university students were engaged through freshers' events at the start of the new academic year.

- Pensioners were engaged through Age Concern groups to promote Pharmacy First.
- Work with urgent treatment centres to formulate a digital, auditable pathway where eligible patients who initially present at their doors can be officially referred into community pharmacy.

The Pharmacy First message was reinforced, clarifying patient eligibility to improve patient and carer knowledge to self-refer to a community pharmacy without the need to see a GP. There was an increase in Pharmacy First activity, due to partnership working between the LPC and ICB on a robust communication plan.

Why this model performs well:

- Strong community pharmacy culture that is valued locally.
- An engaged ICB.
- Established minor ailment legacy schemes.
- Funded ICB coaching teams to work with GP practices and community pharmacies.
- Funded PCN community pharmacy leads.
- Effective NHS 111 referral flow.

3.3 Case Study: Nova Scotia's Community Pharmacy Primary Care Clinics (CPPCC)

Nova Scotia is a Canadian province with strong cultural links to both Scotland and Ireland. This province could be considered another Celtic nation. Nova Scotia represents a mature 'Pharmacy Forward' model.

Nova Scotia's Community Pharmacy Primary Care Clinics (CPPCC) are pharmacist-led clinics providing free, accessible and timely care for minor ailments and chronic disease management. Launched by the Pharmacy Association of Nova Scotia (PANS), Government of Nova Scotia, and Nova Scotia Health, these clinics aim to reduce pressure on emergency departments by offering appointments for services like treating strep throat, UTI assessments, and prescription renewals, often for residents without a family doctor.

Key Aspects of the CPPCC Program:

- **Services Provided:** Pharmacists can assess and prescribe for 26 minor ailments (also referred to as common conditions and infections). The model integrates:
  - Prescription renewals.
  - Minor ailment prescribing.
  - Chronic disease management (hypertension, type 2 diabetes).
  - Workforce development programmes.
  - INT testing.
  - Mental health and addiction services.
  - Public vaccination delivery.

  (The full scope of the services provided can be found here.)
- **Accessibility:** Services are free for anyone with a valid Nova Scotia health card.
- **Personnel:** Primarily staffed by pharmacists, with support from pharmacy technicians for tasks like injections. There are two out of 44 pharmacies piloting pharmacy technicians,

but this is not officially part of the program or the previous evaluation. For personnel, clinics are required to have a dedicated pharmacist and a dedicated clinic administrative assistant for every hour they are open for appointment-based services.

- **Role:** These clinics operate as part of a provincial strategy to improve primary care access, particularly in areas with high rates of people on the 'Need a Family Practice' registry.
- **Location:** They are in select community pharmacies across the province.
- **Evaluation:** A Research Power Inc. evaluation indicated high patient satisfaction, noting successful diversion of patients from emergency rooms and walk-in clinics.
- **Workflow:** In addition to providing access to care, another goal of this clinic model was to separate the workflow and o[er appointment-based services separately from the traditional dispensing process. The evaluation showed that this change resulted in reduced stress, burnout and increased job satisfaction amongst pharmacists.

The Community Pharmacy Primary Care Clinics 'Final Learning and Evaluation Report'[7] showed that between February 2023 and October 2024:

- Over 218,000 healthcare services were delivered.
- 46 pharmacy clinic sites were established following expansion.
- 98% patient satisfaction (rated 8/10 or higher).
- 10% of patients would otherwise have attended emergency departments.
- More than 25% would have attended walk-in clinics.

This service has undergone contractual renegotiation for the next 18 months, supporting sustainability by piloting a new hybrid funding model which includes a base hourly rate during hours of operations in addition to billing a percentage of the agreed upon fee per service.

This is no longer a minor ailments service, it is distributed primary care. Attention has been paid to workflow design making good use of pharmacy premises reflecting the change in workflow from dispensing to clinical services. Attention has been paid to fair funding.

Key insights for England from Nova Scotia's approach:

- **Expansion of scope:** Pharmacist primary care clinics demonstrate that pharmacists can go beyond dispensing to provide full-scope primary care, including prescribing for common conditions, which is highly valued by patients.
- **Public awareness and trust:** The high-profile clinics in Nova Scotia have successfully raised public awareness of the pharmacist's role as a primary care provider.
- **Addressing capacity:** The new funding model is now in place and highlights the need for sustainable funding to support pharmacists in taking on more clinical, patient-facing roles.

Glenn Rodrigues

The importance of pharmacy leadership has been key to the success of this provincial pharmacy model of care. This article pays tribute to Glenn Rodrigues, the Coordinator Thrive Manager Support Program/Pharmacy Practice Facilitator, who provided exemplar pharmacy leadership.

Sadly, during the writing of the article, Glenn passed away leaving a major pharmacy legacy to Nova Scotia. This article pays tribute to his exemplar leadership and dedicated service.

- **System integration:** The clinics show that pharmacists can effectively manage both attached and unattached patients, relieving pressure on emergency departments and urgent care.
- **Lessons on implementation:** Nova Scotia utilised behaviour change theory to transition pharmacists to higher-level clinical roles.

Lesson for England

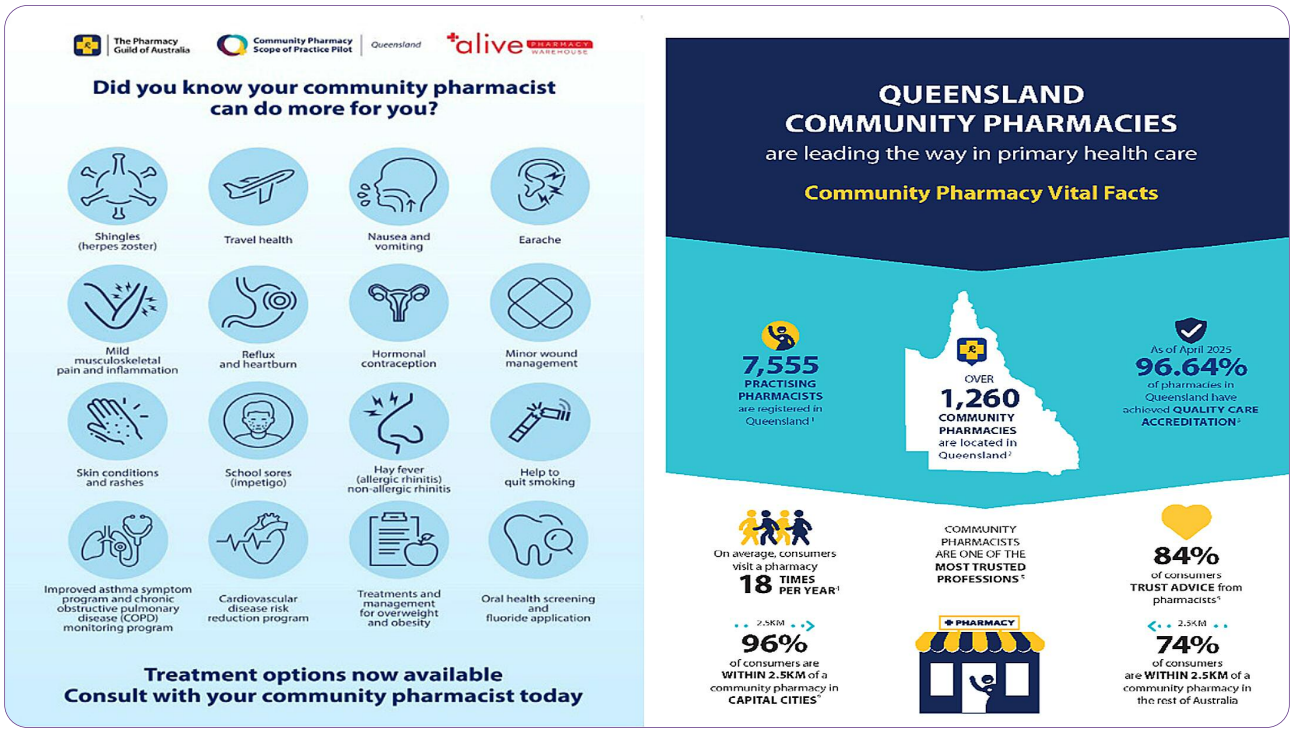
The Nova Scotia model reinforces the ongoing professional evolution of pharmacists. Carefully planned funding, professional leadership and providing support for changes to workflow to support pharmacy premises to deliver a clinical model provide key learning for England).

3.4 Case Study: Queensland – Prescribing Governance at Scale

Queenslanders have access to treatment for acute and minor health conditions, delivered conveniently through their local community pharmacies.

The conditions covered include the following:

- Acute exacerbations of mild plaque psoriasis.
- Acute minor wound management.
- Acute nausea and vomiting.
- Acute otitis externa.
- Acute otitis media.
- Gastro-oesophageal reflux and gastro-oesophageal reflux disease.
- Herpes zoster (shingles).
- Hormonal contraception.
- Impetigo.
- Management for overweight and obesity.
- Mild to moderate acne.
- Mild to moderate atopic dermatitis.
- Mild acute musculoskeletal pain.
- Smoking cessation.
- Travel health.



According to The acting President of the Pharmacy Guild of Queensland Cate Whalan:

> **"97% of people who live in metropolitan areas live within 2.5 kilometres of their nearest community pharmacy, and 83% of regional Australians live within five kilometres of their nearest pharmacy.'"**

For Queenslanders, this will mean greater choice and availability when it comes to accessing health services for these conditions. This improved access and choice will lead to better health outcomes for more patients and demonstrate that acute care provided by community pharmacists is a sustainable solution for a healthier state. There are some parallels between the Queensland Pharmacy model and those services in Scotland, Wales and Northern Ireland.

From 1 July 2025, Queensland transitioned pilot pharmacist prescribing into business-as-usual service delivery guidance-prescribing-scope of practice. The framework includes:

- Defined service-level and individual scope of practice guidance-prescribing-scope of practice.
- Recency-of-practice requirements.
- Structured self-assessment.
- Professional Development Planning (PDP) templates.
- Governance expectations for pharmacy owners.

The guidance makes clear that prescribing authority must align with competence, and this recent guidance on the prescribing scope of practice reduces risk while expanding autonomy.

Australian data show:

- 64% of pharmacy businesses have fundamentally changed their models in recent years.
- Total pharmacy spend increased by 33.7% between July 2019 and January 2023.
- 70% of consumers sought pharmacist advice in the preceding 12 months.

Community pharmacy in Queensland has become a frontline health destination, supported by IT investment and consultation room expansion offering independent prescribing for a wide range of conditions. Next steps for the Queensland model are to:

1. Extend the model to other Australian States (this is well underway).
2. Seek Medicare or similar funding – the current model is 'fee for service', privately funded, therefore excluding vulnerable elements of the community, which is inconsistent with the 'universal access to healthcare' model in Australia.
3. Transitioning the postgraduate training into undergraduate (Extended Masters) education, so that pharmacists graduate with the required competencies, therefore mainstreaming the competencies. A pharmacist with the competencies will have general (not extended) registration, and those without will have restrictions or notations applied to their registration. The first university intends to commence this model in 2027.

Lesson for England

Independent prescribing must be embedded within the formal governance architecture of pharmacy services. This Australian case study offering a wide range of conditions is a proven success story of making community pharmacy the front door to primary care in Queensland.

4 Key Structural Gaps in England

In two years, despite progress in Pharmacy First, six gaps remain:

1. **Referral dependency** – GP signposting variability limits activity.

2. **IT interoperability** – Inconsistent system integration across England linking community pharmacy into primary care and with acute providers.
3. **Independent prescribing scale** – The workforce pipeline is incomplete, with challenges faced by community pharmacists to designated prescribing practitioner.
4. **ICB variation** – Delegation maturity is uneven across England. The ICB mergers as part of primary care efficiencies create uncertainty for local pharmaceutical committees.
5. **Funding certainty** – Contractual instability undermines confidence.
6. **Changing primary care landscape** – The rise of the National Neighbourhood Health Implementation Programme (NNHIP) marks a significant shift in the UK's healthcare, aimed at building a national network of Integrated Neighbourhood Teams (INTs) to move care from hospitals into local communities. This provides opportunities and more clarity on how smaller and leaner ICBs will manage the new primary care landscape, particularly ensuring there is community pharmacy leadership strategically in ICBs and locally within integrated neighbourhood teams.

Pharmacy First service activity growth may stall without addressing these issues.

5. Strategic Recommendations: Moving to Pharmacy Forward

There has been some progress in 2025. There is now the national emergency contraception service under the pharmacy contraception service. The 2026-2027 changes9 to the GP contract bring community pharmacy even more into primary care through new additional regulations to be added in 2026 to improve access and communication between the GP/community pharmacy interface. This is still a great opportunity for increased referrals for not just Pharmacy First, but also other pharmacy services such as the hypertension case finding service, and the pharmacy contraception service.

The Neighbourhood Health Framework published in March 2026 is an important step forward in INTs. The direction of travel is clear:

- Care closer to home.
- Stronger integration
- A focus on prevention and population health

The key issue is that there is no mandate or regulation to uphold this vision, namely community pharmacy involvement at these strategic discussions. If community Pharmacy participation is needed, and CPCF services such as Pharmacy first are to be truly integrated, their participation is needed. For neighbourhood health and INTs to truly succeed community pharmacy needs to be part of the co-design.

To achieve Pharmacy Forward, the following recommendations are made to realise the potential of community pharmacists as the front door to primary care:

1. **Expand clinical pathways** – Increase conditions beyond seven — ENT, dermatology, wider contraception, chronic disease review. There are mature community pharmacy services in the Celtic nations and abroad which meet the shift left agenda.
2. **Embed independent prescribing** – Accelerate training and create structured governance aligned with Queensland's framework guidance on prescribing.
3. **Reduce service dependence on GP referrals** – Promote Pharmacy First as a walk-in, patient-initiated service.
4. **Commission self-referral nationally** – Replicate Cornwall's WIC model Walk-in Consultation Service that complements the Pharmacy First service.
5. **Develop a structured ARRS framework** – For all community pharmacy roles, i.e. the pharmacist, pharmacy technician, dispenser, front-line staff and foundation pharmacist, so they have a role to play in pharmacy first and other services.

6. **Develop pharmacy neighbourhood community pharmacy leads** – Several ICBs have embedded place-based leadership models nationally to ensure community pharmacy is truly integrated at place and within integrated neighbourhood teams. (This was covered in last year's article).
7. **Introduce multi-year contract stability** – Link CPCF reform to NHS long-term community care strategy.
8. **Align training hubs across primary care** – Ensure community pharmacy equitable access to workforce investment.
9. **Invest in digital interoperability** – Mandate referral integration within GP triage tools, NHS 111 and acute referral tools. This will develop the digital front door to community pharmacy.
10. **Establish national outcomes dashboard** – This will be an outcome-based measurement to look at acute referrals, GP appointment releases, NHS 111 referrals and to ensure patient satisfaction is measured. Elective recovery relied on national dashboards and clear performance expectations. The implication for ICBs to implement national dashboards to measure pharmacy integration using system-level metrics such as:
    - GP appointments avoided.
    - Same-day access improvement.
    - Re-consultation rates.
    - Escalation to GP/secondary care.
    - Patient experience.
    - Impact on health inequalities.

These outcomes would be compelling evidence to show the shift left effect of community pharmacy.

11. **Organisational and commissioning changes** – Pharmacy First must be contractually embedded with PCNs and INTs to avoid variable GP uptake. The CPCF and GMS/PMS contract must be made more mutually interdependent to strengthen interprofessional collaboration. There is some progress in the new GP contract for 2026/27.
12. **Lessons from elective care recovery** – The NHS elective recovery programme has demonstrated that sustainable improvements in access occur when services are redesigned at a system level, rather than through isolated initiatives. Key features of elective recovery, such as dedicated capacity, standardised pathways, referral optimisation, digital integration and strong performance management, o[er a clear blueprint for embedding community pharmacy more effectively within neighbourhood health systems.

Community pharmacies represent the most accessible clinical workforce in the NHS, with over 11,000 locations in England, and are already delivering structured services such as Pharmacy First, hypertension case-finding and contraception services. If embedded properly within primary care access models, community pharmacy can:

- Reduce avoidable GP appointments.
- Improve same-day access for patients.
- Support long-term condition monitoring.
- Reduce pressure on urgent care and elective pathways.

Key Lessons from the Elective Recovery Programme to embed community pharmacy further in primary care

12a) **Create Protected Capacity** – Elective surgical hubs improved productivity because elective work was ring-fenced from emergency demand.

Implication for pharmacy – ICBs should move from opportunistic pharmacy use to commissioned consultation capacity within community pharmacies, ensuring:

- Protected clinical consultation time.
- Predictable funding models.
- Stable referral routes from GP practices and NHS 111.

Without this, Pharmacy First remains a pressure valve rather than a core access channel.

12b) **Standardise Pathways Across Systems** – Elective reform standardised clinical pathways and referral criteria.

Implication for pharmacy – A national concerted approach reducing local variation improves patient understanding and GP confidence in pharmacy services.

12c) **Integrate Pharmacy into Triage and Referral Systems** – Elective reform improved referral optimisation through Advice and Guidance and clinical triage.

Implication for pharmacy – Pharmacy must be embedded within primary care triage systems, including:

- GP digital triage platforms.
- NHS 111 referrals.
- Urgent treatment centre streaming.
- Self-referral via NHS App.
- This shifts pharmacy from informal signposting to a formal clinical pathway.

12d) **Shift Routine Follow-up Activity** – Elective recovery programmes aim to reduce unnecessary follow-up appointments through remote monitoring and patient-initiated follow-up.

Implication for pharmacy – Community pharmacy can safely manage suitable follow-up activity including:

- Medicines optimisation.
- Inhaler technique reviews.
- Blood pressure monitoring.
- Contraception continuation.
- Minor medicines queries.

This releases capacity in general practice and outpatient clinics.

12e) **Invest in AI and Digital tools** – Elective recovery has been supported by digital infrastructure including referral management systems and the NHS App. The development of AI total triage platforms, making the front-door of general practice Pharmacy First referral effective, friendly and efficient.

Implication for pharmacy – To embed pharmacy effectively, systems must support:

- Two-way referrals between GP and pharmacy.
- Integrated clinical record access.
- Outcome reporting to GP systems.
- Pharmacy booking via digital triage platforms.

Digital connectivity is essential for pharmacy to function as part of the clinical pathway rather than as a peripheral service.

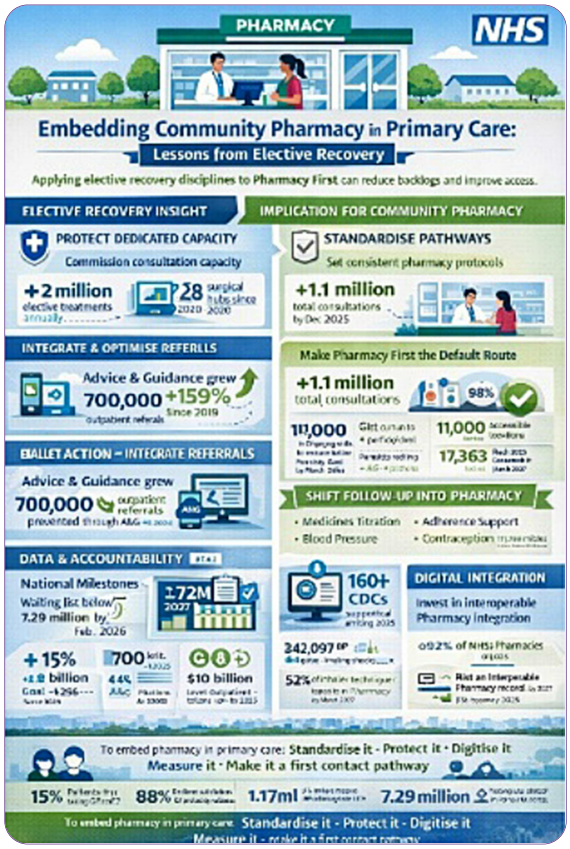
The elective care recovery programme demonstrates that sustainable improvement requires structural integration, protected capacity and clear pathways. This would maximise not only Pharmacy First, but also the Pharmacy Contraception service, and the hypertension case finding service.

Applying these principles to community pharmacy would transform Pharmacy First from a standalone service into a core component of primary care access, improving patient experience while reducing pressure across general practice, urgent care and elective service.

6. Conclusion: The Climb Ahead to Pharmacy Forward

England's Pharmacy First programme has demonstrated operational competence at scale, and activity is rising. Public trust is evident and the workforce is willing. The Celtic nations and international comparators show what is possible when:

- The clinical service offering is expanded.
- Prescribing is embedded.
- Funding is stabilised.
- Governance is formalised.
- Integration is deliberate.
- Independent prescribing is integrated.



Pharmacy First has proven capability, and Pharmacy Forward must now deliver permanence. The ascent to Pharmacy Forward requires courage from commissioners and contractors alike.

A complete restructuring and reimagining of community pharmacy as the front door of primary care means the summit could be within reach.

References

1. PM Healthcare Journal, Winter 2025, Issue 11: Achievements of Community Pharmacy Integration in the Celtic nations – What are the lessons for England to move from Pharmacy First to Pharmacy Forward? David Tamby Rajah. (Accessed 20 March 2026)
2. Company Chemists' Association: Pharmacy First: Supporting Antimicrobial stewardship, December 2024. (Accessed 20 March 2026)
3. Company Chemists' Association: Pharmacy First Insights from the LPC Network, September 2024. (Accessed 20 March 2026)
4. Company Chemists' Association: The Future of Pharmacy First – Maximising Patient Benefit, January 2025. (Accessed 20 March 2026)
5. Pharmacy Magazine: NPA chair reminds public about Pharmacy First UTI help after report warns of hospital costs, 15 July 2025. (Accessed 20 March 2026)
6. Chemist & Drugist: GP referrals to Pharmacy First must be reduced, says IPA, 4 February 2026. (Accessed 20 March 2026)
7. Pharmacy Association of Nova Scotia: Community Pharmacy Primary Care Clinics: Final Learning and Evaluation Report, March 2025. (Accessed 20 March 2026)
8. Queensland Health: Quality and safety management Prescribing in community pharmacy, July 2025. (Accessed 20 March 2026)
9. NHS England: Reforming Elective care for patients, 6 January 2025. (Accessed 20 March 2026)
10. NHS England: Changes to the GP contract 2026/27, 24 February 2026. (Accessed 20 March 2026)
11. NHS England: Neighbourhood Health Framework, 17 March 2026. (Accessed 20 March 2026)
12. Community Pharmacy perspective on the Neighbourhood Health Framework – Amit Patel CEO SW London LPC LinkedIn March 2026. (Accessed 28 March 2026)


AI Chatbot
AI assistant
Ai
Prompt:
50%
Data # 1
55%
Data # 2
73%
Data # 3
80%
Data # 4
Generate

Pharmacy IT: State of the Nation

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During the last fifty years, information technology has revolutionised the working lives of pharmacy teams. From the early patient medication record (PMR) systems used by pharmacists for labelling and stock control in the pharmacy, digital systems are now in place to handle information on medicines and pharmacy in a range of settings. These systems enable clinical work relating to medicines to be carried out safely and efficiently and also enable new ways of working that were hitherto impossible – for example, closed-loop electronic prescribing and medicines administration in hospitals, and the integration of the community pharmacy network with other NHS services. Use of digital technologies to handle medicines-related processes means that pharmacists are able to spend more time with people, providing patient-focused services, and supporting people taking medicines – for example, educating them on their medicines, advising them about newly-prescribed medicines, and helping them to be concordant with their therapy.

Digital systems that store medicines information and facilitate medicines-related processes are now widely used in health services. Pharmacy PMR systems and GP practice systems have been in use for many years for managing information on prescribing and dispensing histories and, in recent years, developments with these systems have focused on technical capability – for example, development of a cloud-based architecture, and integration with other systems, including mobile phone apps.

In the last thirty years, there has been gradual development of various other digital systems that support medicines use and pharmacy, with increasing digital maturity over time. Electronic health records (EHRs) have increasingly been adopted, often as modular systems, by hospitals and healthcare providers, and contain prescribing histories and a wealth of other useful information on medicines and therapeutics. As such, they provide a rich source of information on prescribing patterns, which can be used to monitor quality of care. In addition, there are national care records – such as the England National Care Records Service – which can be accessed by a range of health and care professionals, so that the necessary information on a patient's medicines can be available to a healthcare professional at the point of care, regardless of care setting.

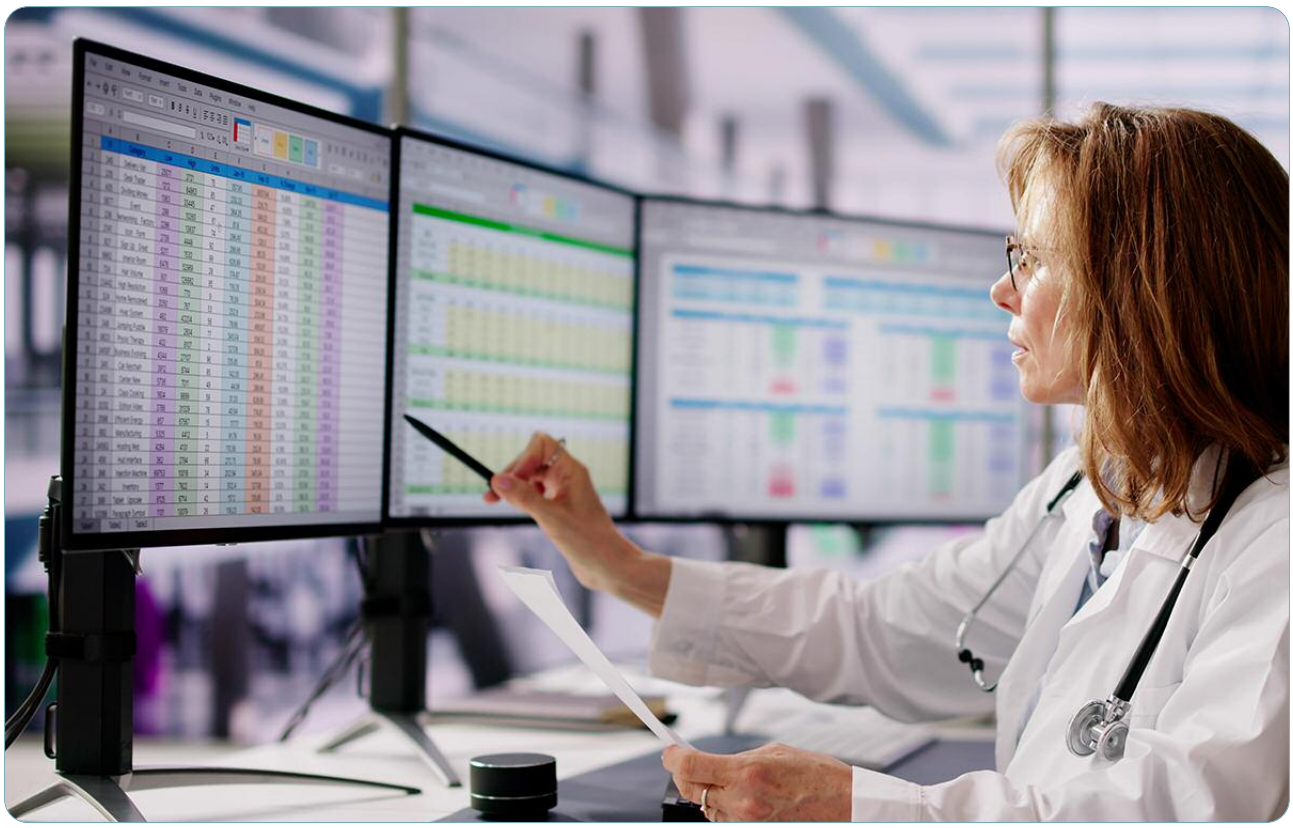
Electronic prescribing and medicines administration (EPMA) systems in hospitals facilitate the safe and efficient prescribing and administration of medicines in hospital settings. They may also improve medicines-related workflows in hospitals and improve quality of care. In England, EPMA system adoption was significantly accelerated by government investment from 2013 onwards. Nevertheless, there is now considerable evidence that these systems are not plug- and-play systems but instead need ongoing optimisation of configuration in situ, to maintain their safety and utility. There are also some concerns emerging about how they affect inter- personal communications between healthcare professionals.

Electronic medicines administration record (eMAR) support administration of medicines in care homes and other long-term care facilities and therefore are functionally similar to the administration component of an EPMA system. These systems were initially widely adopted in the United States, and recent government information indicates that digital care records are now used by the majority (around 80%) of UK care providers.[1] These systems have been generally well received by care home staff, according to usage surveys; however, unlike EPMA systems, there is still little robust data on their impact on patient safety.

Pharmacy robots were adopted widely in UK hospitals following the trend to re-engineer and decentralise hospital pharmacy services 25 years ago; indeed, at present, some hospitals are installing second-generation robots. However, there are still relatively few robots installed in UK community pharmacies. The available evidence indicates that pharmacy robots reduce dispensing errors, and also improve dispensing process efficiency, facilitate good stock control in the pharmacy and enable cost-effective use of space in the department. Since the widespread adoption of pharmacy robots, there has also been a gradual adoption of automated medicine cabinets on hospital wards to facilitate closed-loop medicines administration. These not only improve patient safety but also facilitate good stock control with medicines on the wards.

"In the last twenty years, there have been significant technology developments that have impacted the functionality that medicines and pharmacy digital systems can offer. These include widespread internet access, and thus adoption of cloud-based systems, the development of increasingly complex and versatile mobile phone apps, and the development and adoption of clinical terminologies (SNOMED CT, dm+d and FHIR) and clinical record standards to enable electronic interoperability."

This means that systems that were formerly only available in a siloed manner on local computers or hospital servers are increasingly connected with other systems and may be accessed remotely using mobile devices. This, in turn, has enabled developments such as patient access to electronic health records and the use of mobile phone apps, such as the NHS App, to manage prescriptions and appointments. It has also enabled connectivity



between different care settings, which supports a number of medicines-related processes. One of these is the transfer of discharge medicines information from the hospital to the community pharmacy, to ensure adequate communication of information on medicines changes in hospital. Another is referrals of patients into community pharmacy for a range of patient- focused services, such as vaccinations, minor ailments, urgent supply or the management of some specific conditions (*Pharmacy First* clinical pathways). With these services, after the pharmacist has conducted the consultation with the patient, the pharmacist's actions and recommendations are then communicated onwards to the patient's general practitioner. In terms of digital technology, these services are supported by web-based pharmacy services support systems, and the overall impact is that community pharmacists are integrated into the wider health service, and their clinical skills are used appropriately. Community pharmacy integration has the potential benefits of ensuring prompt patient care and easier access to treatment, and also reduction of GP workload. As well as increased connectivity between care settings and the new ways of working this enables, electronic interoperability also opens up the possibility of collating different types of data (patient data, prescribing trends, medicines information) to facilitate data-driven care, where data is used to answer specific therapeutic questions to enable evidence-based decision-making. Another important area of technological development has been the increasing use of video conferencing technologies to enable remote consultations. This has been partly because, with electronic referrals, services can be provided to patients who cannot physically access the pharmacy or who may not be located near the pharmacy, but the COVID pandemic of 2020-2021 accelerated these developments.

A number of future prospects for pharmacy and medicines digital technology are now emerging. These include the use of artificial intelligence (AI) systems. As well as facilitating sophisticated data-driven care and clinical decision-making, AI systems are used for ambient consultation support and have potential for use in adverse event reporting and adherence monitoring. A range of devices and wearables – for example, 'smart' inhalers – are being prototyped to support disease monitoring and therapy adherence. Moreover, both increasing computing power and AI systems will be used in future to support analysis of genome datasets, and enable pharmacogenomic medicine, where therapy is customised to the patient's genomic profile.

Digital technology is now almost universally available to healthcare providers in the UK and enables significant transformation in working practices due to its increasingly connected and integrated functional processes. However, all digital systems are sociotechnical systems, meaning that their overall effects are dependent not only on their technical functionality but also the organisational contexts in which they operate and the behaviours of their human users. This means that, due to their increasing connectivity, digital systems can exert significant effects on user behaviours, and on the information they hold about patients (data subjects) – and therefore they may give rise to various ethical issues. These include privacy, algorithmic bias and their impact on the autonomy of human users. Data privacy is an ethical issue as it is a prerequisite for patient confidentiality. Privacy has always been a consideration with digital systems but will become a more acute concern in the future due to increasing connectedness of systems, greater diffusion of data and more widespread access, as well as the possibility of AI systems disclosing information in a semi-autonomous way. Second, systemic bias, where the system operation introduces functional biases that compromise the care of certain patient groups, contributes to health inequalities in society, and will be increasingly hard to detect in widespread, connected systems, where patient outcomes across the system are unclear. For example, it is well recognised that, due either to their internal algorithmic operation or to the biometric interfaces they use, some clinical systems discriminate against people of colour.[2]

A third ethical issue with connected digital systems, arising from their impact on both patient data and clinical user behaviour, is their effects on user and data subject autonomy. Some systems will prioritise the autonomy of the patient over that of the clinical user, or vice versa, which will introduce ethical problems depending on the clinical scenario. Studies with the England Electronic Prescription Service (EPS) indicate that, in the system, there is a balance between user agency and the system's ability to determine user actions in such a way that the risks of the system are socially constructed (what researchers call 'technological affordances').[3] For this reason, such systems are able to redefine professional boundaries, manipulate professional roles and redistribute power among the users of the system. These and other factors affecting the human values of patients, healthcare professionals and healthcare providers will need to be monitored in future as digital systems become more widespread and diffuse their operation. It will be especially the case with AI systems which will be potentially highly disruptive as they are implemented; indeed the 'alignment issue' – the alignment of AI functional capability and human values in society – is a subject of ongoing debate with AI systems.

"*Information Technology: An Integrated Approach* describes and discusses these and other important issues in relation to pharmacy professional practice, drawing on a wealth of academic research and professional experience. It takes the approach that pharmacists and pharmacy managers will increasingly need to take a holistic approach to the use of digital pharmacy technologies in order to realise their benefits. It also stresses that this is an ongoing task. Often it is supposed that, once the 'ideal' digital systems are in place, the healthcare setting will resemble a utopian perfection, where patient outcomes are always good, patients are always happy, and healthcare professionals always find patient care rewarding."

The reality is that healthcare providers are imperfect, human organisations and healthcare

digital systems are sociotechnical systems, deeply enmeshed with the human organisational environment. It is clear, therefore, that digital medicines and pharmacy systems are always 'work-in-progress'; they require ongoing monitoring, so that they can be fine-tuned in configuration to ensure optimal safety and efficiency of operation, and also to ensure that their operation is aligned with the human values that enable high quality healthcare and professional practice.

References

1. UK Government. Digital revolution in care saves millions of admin hours. https://www.gov.uk/government/news/digital-revolution-in-care-saves-millions-of-admin-hours. Accessed March 2026.
2. Chin MH et al. Guiding principles to address the impact of algorithm bias on racial and ethnic disparities in health and health care. *JAMA Network Open.* 2023; 6(12): e2345050.
3. Petrakaki D et al. Technological affordances of risk and blame: the case of the electronic prescription service in England. *Sociology of Health & Illness.* 2014; 36(5): 703-18.

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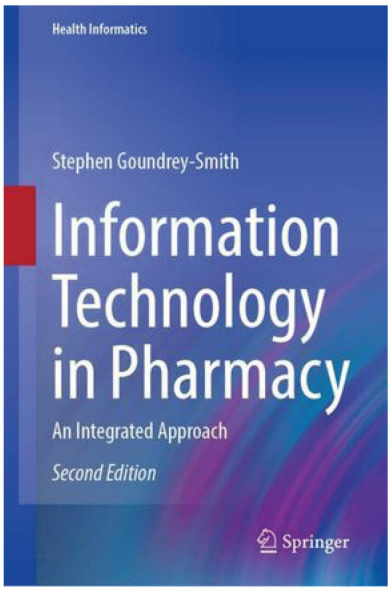
Information Technology in Pharmacy



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What it really takes to implement AI-supported consultations in community pharmacy

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About the author

Asif Mukhtar is a Consultant Pharmacist and Founder & CEO of PharmBot AI, where he leads the development of AI-enabled clinical infrastructure designed to support structured service delivery in community pharmacy. His work focuses on bridging the gap between technological capability and real-world workflow, ensuring that digital systems align with governance, accountability and everyday practice.

With over a decade of experience across community and clinical pharmacy, Asif has seen first- hand the operational and regulatory pressures facing the profession. Through PharmBot AI and its Pharmacy First pathway platform, he is working to support safe, transparent and scalable consultation models that integrate with commissioning frameworks rather than operate alongside them.

He has contributed to national discussions on digital health and has participated in initiatives including the DigitalHealth.London RADIANT-CERSI Innovator Support Programme. PharmBot AI has been recognised through national award nominations, including the HSJ Partnership Awards and the HealthInvestor Awards, reflecting growing interest in pharmacy-led digital innovation.

Asif's work combines clinical governance, systems thinking and technological development, with a clear emphasis on ensuring that AI supports rather than replaces professional judgement.

1.0 Introduction: From AI Enthusiasm to Operational Reality

Artificial intelligence now occupies a central place in conversations across the National Health Service. Policy documents, conference panels and transformation programmes increasingly position AI as a catalyst for workforce sustainability, improved access and safer clinical decision-making. The narrative is confident: technology will relieve pressure, reduce variation and enhance productivity.

Community pharmacy sits directly within this transformation agenda.

Over the past decade and particularly with the introduction of Pharmacy First, the role of the pharmacist has shifted from primarily dispensing medicines to delivering structured, protocol-driven clinical consultations. With this evolution has come greater accountability, increased documentation requirements and more formalised decision-making under Patient Group Directions (PGDs). Consultations that were once informal are now auditable clinical events.

This structural shift has profound digital implications.

As consultation pathways become more defined and expectations around record-keeping intensify, the question is no longer whether community pharmacy needs digital support but what kind. AI-supported consultation systems are often presented as the logical next step. They promise structured questioning, decision support and automated documentation. In theory, they align perfectly with the direction of travel.

In practice, implementation is far more complex.

AI in community pharmacy does not succeed because it is technically sophisticated. It succeeds or fails at the level of workflow. A live consultation unfolds in an environment shaped by interruptions, competing demands, staffing variability and professional judgement exercised in real time. The pharmacist is accountable for the final decision, regardless of any digital assistance. If a system adds friction, duplicates documentation, slows the pace or creates uncertainty, it will be quietly abandoned no matter how intelligent its underlying model.

> "This is the implementation paradox: enthusiasm is generated at the strategic level, but survival is determined on a Tuesday morning at 10:17am when the phone is ringing, the counter is busy and a consultation must be completed safely and efficiently."

This article explores what it really takes to turn an AI vision into something that works in everyday practice. It suggests that long-term success depends less on how advanced the technology is, and more on whether it fits into real workflows, supports clear governance, enables transparent documentation and improves over time through practical use. In community pharmacy, innovation only becomes meaningful when it can withstand the pressures and interruptions of routine practice.

2.0 Pharmacy First as a Structural Inflection Point

The introduction of Pharmacy First represents more than a new funded service line within the National Health Service. It marks a structural inflection point in the clinical identity of community pharmacy.

Historically, many minor ailment consultations in pharmacy were informal, advisory and lightly documented. Professional judgement was exercised, but rarely within a nationally standardised consultation framework. Pharmacy First alters that dynamic.

It formalises defined clinical pathways, establishes eligibility criteria, embeds decision-making under Patient Group Directions (PGDs), and introduces clearer expectations around documentation, auditability, and outcome reporting.

In doing so, it raises the operational bar.

Pharmacists are now required to conduct structured clinical assessments within time- pressured retail environments, ensure protocol adherence, capture defensible records and maintain patient flow often

simultaneously. Each consultation is no longer simply an interaction; it is a traceable clinical event that may be reviewed by commissioners or regulators. The margin for inconsistency narrows.

This structural shift reframes the digital conversation.

AI-supported consultation tools are frequently discussed as innovation. In the context of Pharmacy First, they are better understood as potential infrastructure. When pathways are predefined, when documentation requirements are explicit, and when service reimbursement depends on accurate reporting, structured digital support becomes less a technological enhancement and more an operational response to complexity.

However, the presence of a structured pathway does not automatically justify digital intervention. It simply creates conditions in which digital support may add value if implemented correctly. The consultation still takes place in a live environment characterised by interruptions, competing priorities and professional accountability. Any system introduced must align with that reality.

"Pharmacy First therefore serves as both opportunity and stress test. It provides a defined clinical framework around which digital systems can be built. At the same time, it exposes weaknesses in poorly integrated tools. If digital consultation support disrupts workflow, duplicates documentation or obscures professional judgement, it will quickly be rejected in practice."

The significance of Pharmacy First lies not only in expanded scope, but in heightened responsibility. As community pharmacy assumes a more formalised clinical role within the NHS, the need for structured, defensible, and efficient consultation processes becomes unavoidable. Digital systems that recognise this structural shift and respond to it with discipline rather than novelty are more likely to endure.

3.0 From Demonstration to Deployment: The Implementation Gap

In digital health, demonstration is relatively easy, deployment is not.

AI-supported consultation tools often perform impressively in controlled environments. In a quiet room, with uninterrupted time and a clearly defined scenario, structured questioning flows logically. Outputs appear coherent. Documentation is generated neatly. Stakeholders observing a demonstration can readily see the potential.

But a community pharmacy at 10:30am on a weekday is not a controlled environment.

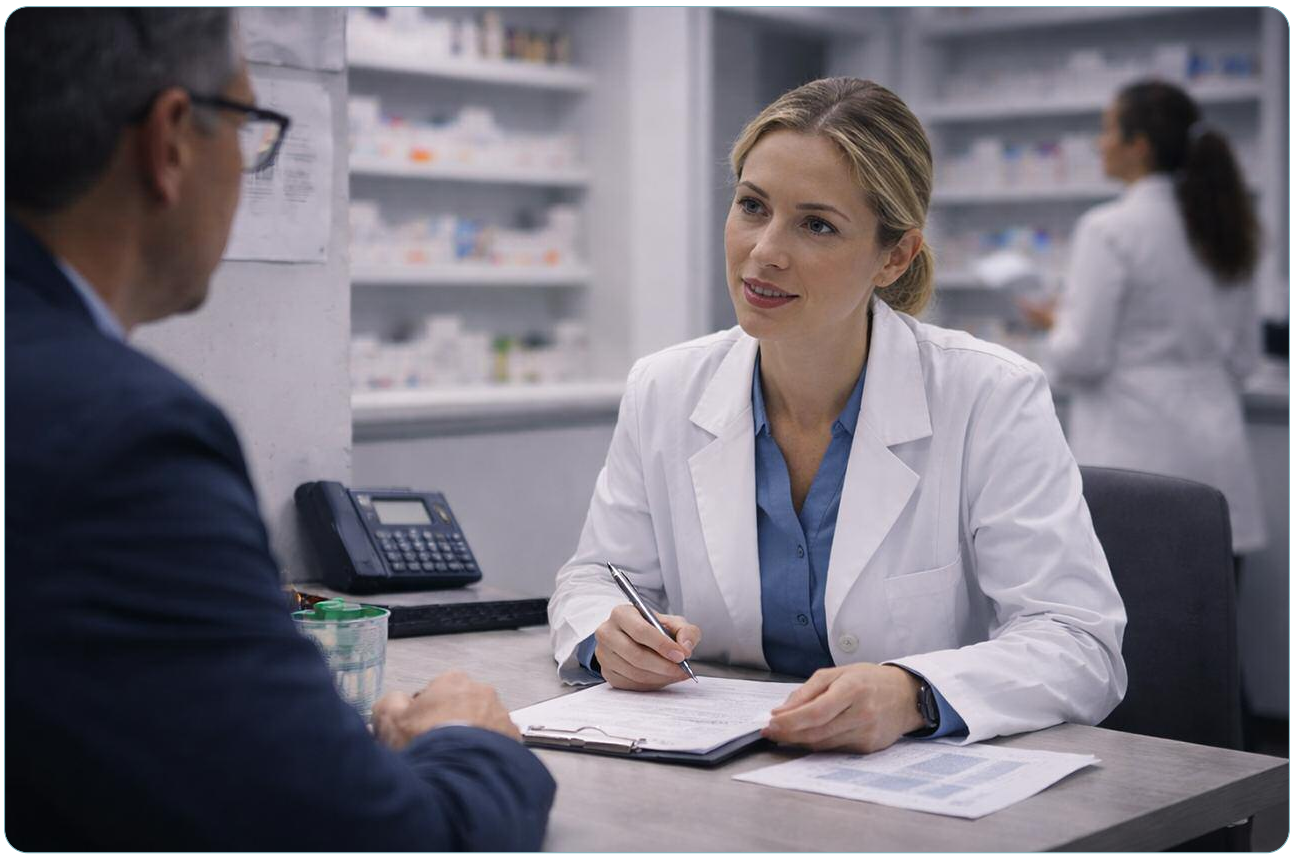
A pharmacist conducting a consultation may be interrupted by a dispensing query, a delivery driver, a phone call from a GP surgery or a counter staff member seeking clarification. Staffing levels fluctuate. Patients arrive without appointments. Clinical complexity varies unpredictably. Professional judgement is exercised dynamically, not linearly.

It is within this environment that AI systems must function.

The implementation gap emerges when a tool designed for demonstration fails to account for workflow rhythm. Pharmacists do not move through consultations as uninterrupted sequences of prompts. They pause, adapt, summarise and revisit information while managing operational demands. A digital system that assumes sequential perfection quickly becomes burdensome.

Time pressure magnifies this effect.

If an AI-supported tool duplicates documentation requiring input into both a consultation platform and a separate pharmacy system it introduces friction. Even a small increase in consultation time, multiplied across a busy day, becomes unsustainable. The result is predictable: workarounds develop, usage declines and the system is side-lined.



Integration therefore matters more than sophistication.

Even if an AI system is very clever, it can still cause problems if it is hard to use. If it takes too many clicks, asks for too much information, or makes staff log in again and again, it slows everything down. In community pharmacy, speed matters. Patients expect quick access to help, and staff need to keep work moving. Any tool that slows things down can quickly become frustrating for both staff and patients.

There is also the question of cognitive load.

Pharmacists remain professionally accountable for final decisions, particularly under Patient Group Directions (PGDs). If an AI system presents recommendations without clarity, or if its reasoning is opaque, it increases mental effort. Instead of supporting judgement, it demands verification. Digital assistance then becomes an additional task rather than a genuine aid.

Successful deployment requires alignment with real practice patterns. Systems must accommodate interruptions, allow flexibility in questioning order, minimise duplication and support rather than replace professional reasoning. They must integrate into existing digital ecosystems rather than operate as parallel processes.

This is where many implementations falter. Demonstrations prove possibility, deployment tests sustainability.

Closing the gap between an idea and real-world use requires developers to be open to feedback and leaders to be clear about what is needed. It means watching how work actually happens in practice, making regular improvements, and focusing on ease of use rather than flashy features. In community pharmacy, having advanced technology is not enough. What really matters is whether the system can work smoothly despite the interruptions, changing situations and professional responsibility that are part of everyday practice.

Only then does innovation move from demonstration to durable deployment.

4.0 Governance Before Innovation: Clinical Safety in Digital Consultation Support

In discussions about AI in healthcare, attention often gravitates toward capability: diagnostic accuracy, natural language fluency, predictive

insight. Yet in community pharmacy, capability is not the primary determinant of adoption, governance is.

Under frameworks such as Pharmacy First, pharmacists operate within defined clinical pathways and Patient Group Directions (PGDs). These are legal mechanisms enabling the supply of prescription-only medicines without a prescription.

Professional accountability for each consultation rests with the pharmacist. No digital system alters that responsibility.

This reality reframes the role of AI-supported consultation tools. They are not decision-makers but decision-support systems within a regulated environment. Their governance architecture must therefore be explicit, transparent and defensible. The importance of governance in AI- supported consultation aligns with emerging professional guidance. The Royal Pharmaceutical Society (RPS) has emphasised that the use of artificial intelligence in pharmacy must remain underpinned by professional accountability, transparency and patient safety. AI systems should support, rather than replace, clinical judgement, with clear lines of responsibility maintained at all times. These principles reinforce the need for digital consultation tools to be designed within established governance frameworks rather than introduced as standalone innovations.

Override capability is foundational. Pharmacists must be able to accept, modify or reject system-generated suggestions without friction. If deviation is difficult, safety and trust are compromised. Governance must ensure clinical judgement remains paramount.

Transparency is equally critical. Outputs without clear rationale increase cognitive burden rather than reduce it. A pharmacist faced with an unexplained suggestion must independently verify the reasoning. Decision support should therefore make its logic visible: which criteria were met, which exclusions applied and why a pathway was followed. Traceable reasoning supports confidence and defensibility in audit.

Clear guidance on when to escalate is essential. The system should clearly highlight warning signs, situations where the patient does not meet the service criteria, and when a referral to a GP or urgent care is needed. These prompts must align with PGDs and local guidance. If the system is unclear about when to escalate, it creates risk. Higher-risk cases should be identified quickly and shown prominently so the pharmacist can act with confidence.

Version control is also central. Clinical pathways evolve, and PGDs are amended. A digitally supported system must demonstrate clear version management documenting updates, changes made and user notification. Without this discipline, scaling becomes unsafe.

"Governance should not be retrofitted after deployment; it must precede scale. Pilot environments should function as governance laboratories, where override patterns are analysed, edge cases identified and documentation workflows refined. This iterative development underpins sustainable adoption."

Commissioners and regulators are unlikely to be persuaded by sophistication alone. They seek assurance of safety, auditability, and clarity of accountability. Tools that foreground governance rather than novelty align more closely with this expectation.

In community pharmacy, scaling AI-supported consultations is not primarily a technological challenge but a governance one. Only when systems are demonstrably safe, transparent and professionally aligned can expansion be justified. Innovation may attract attention, but governance determines longevity.

5.0 Data, Documentation and Traceability

In community pharmacy, innovation is often evaluated through a different lens than in technology sectors. Commissioners and regulators are not primarily persuaded by novelty. They are persuaded by traceability.

Under structured services such as Pharmacy First within the National Health Service, consultations are not informal clinical conversations; they are reimbursable, auditable events. Each assessment must demonstrate eligibility, adherence to pathway criteria, appropriate supply (or referral), and defensible record-keeping.

Documentation is not secondary to care delivery, it is part of the care framework.

AI-supported consultation systems therefore carry a dual responsibility. They must assist clinical reasoning while simultaneously strengthening documentation integrity.

Consistency is the first requirement. Variability in documentation missing fields, incomplete symptom histories, inconsistent coding weakens confidence in service delivery. Structured digital systems can reduce such variability by embedding mandatory fields, guiding question sequences, and ensuring that exclusion criteria are explicitly recorded. However, structure must support clarity rather than create administrative burden.

Auditability follows closely behind. Commissioners require the ability to review consultation records retrospectively. This demands clear time-stamping, identifiable authorship and visible decision pathways. If a system generates outputs without preserving the reasoning trail, it creates vulnerability rather than resilience. Traceable records protect both patient and professional.

Version control is another often overlooked component. Clinical pathways evolve, eligibility criteria change. If consultation tools are updated, there must be a documented record of when changes were implemented and which consultations were completed under which version of guidance. Without such transparency, retrospective review becomes problematic.

Data handling principles also underpin trust. Systems must manage patient information in accordance with information governance standards, ensuring secure storage, controlled access and appropriate retention policies. In pharmacy, reputational risk associated with data mismanagement is significant; therefore, documentation architecture must be robust.

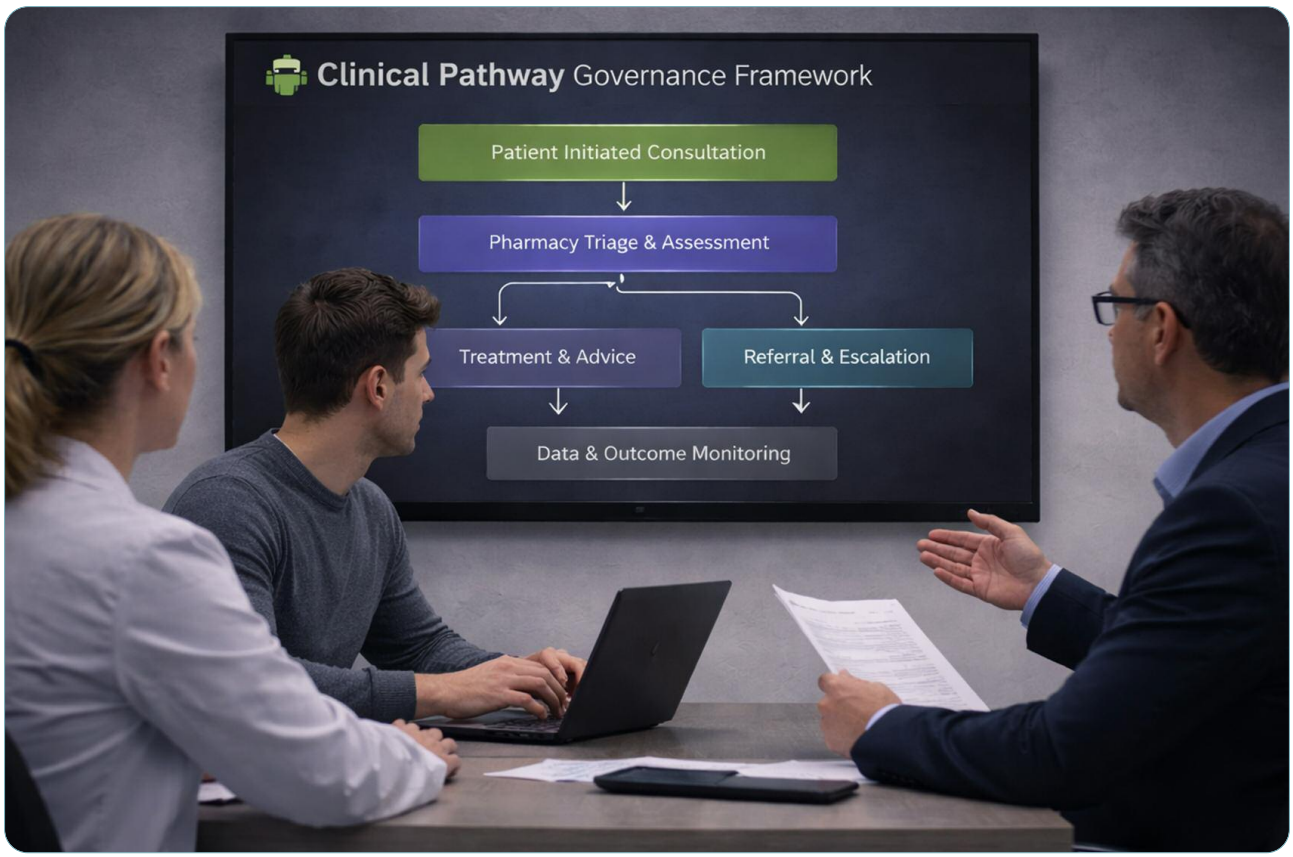
> **"Crucially, digital tools should reduce duplication rather than generate parallel record systems. If pharmacists must transcribe information from one platform into another, data integrity is weakened and workload increases. Integration whether through structured exports, interoperability standards or aligned record formats becomes central to sustainable use."**

Ultimately, trust in AI-supported consultation systems is built less on algorithmic sophistication and more on defensible documentation. When records are consistent, traceable and aligned with service requirements, digital support becomes an asset rather than an uncertainty. In community pharmacy, data discipline is not optional - it is foundational to credibility.

6.0 Human Factors: Adoption in Real Community Pharmacy Environments

Technology implementation in community pharmacy is often discussed in technical terms, integration, functionality, interoperability. Yet many digital initiatives succeed or fail for fundamentally human reasons.

Pharmacists are autonomous clinicians working within a retail-facing healthcare environment. Consultation styles vary: some prefer conversational flow, others structured checklists.



Introducing AI-supported systems into this landscape requires sensitivity to these behavioural differences.

A rigid interface can feel constraining. If questioning sequences cannot adapt to conversational rhythm, the tool may seem intrusive rather than supportive. Adoption depends on alignment with professional identity. Systems perceived as replacing judgement or scripting reasoning are likely to encounter resistance, whereas those positioned as documentation aids or cognitive support tools are more readily accepted.

Cognitive load is a decisive factor.

Consultations occur amid operational pressure, interruptions, queue management and dispensing responsibilities. Even well-designed systems can contribute to overload if they require excessive navigation, repetitive confirmations, or complex data entry. The perception of added effort, however small, shapes behaviour. If a tool feels slower than established practice, usage will decline.

Trust develops gradually.

Initial scepticism is common. Pharmacists may verify recommendations against their own reasoning before relying on them. This phase is natural. Over time, consistent performance and transparent logic can build confidence, but this requires training, repetition, and clarity about system boundaries.

Framing is therefore critical. Presenting AI-supported systems as assistive infrastructure rather than automated decision-makers reinforces accountability and reduces defensiveness. Training should emphasise override capability and confirm that final responsibility remains with the clinician.

Cultural readiness varies between sites. Some pharmacies embrace experimentation; others have limited capacity for change. Incremental rollout, supported onboarding and feedback loops, enable adaptation without overwhelming teams.

Ultimately, digital maturity in community pharmacy is not purely technological but behavioural. Adoption depends on whether systems respect autonomy, reduce cognitive strain and integrate into everyday practice. Without attention to these human factors, even technically sound tools will struggle to endure.

7.0 Small-Scale Pilots as Infrastructure Learning

Digital pilots in healthcare are often positioned as proof-of-concept exercises, demonstrations intended to validate technical feasibility or showcase innovation. In community pharmacy, however, pilots serve a more important function. They are environments for infrastructure learning.

Within services such as Pharmacy First, consultation delivery varies subtly between sites. Differences in staffing models, patient demographics, physical layout and digital maturity influence how new systems are experienced. A tool that performs well in one pharmacy may encounter friction in another. Small-scale pilots allow these contextual variables to surface before wider expansion.

Rather than asking "Does the technology work?", effective pilots ask, "How does the technology behave under real operational conditions?" They examine interruption patterns, consultation duration, override frequency, documentation flow and integration touchpoints. They identify edge cases atypical presentations or workflow deviations that may not have been anticipated during development.

Crucially, pilots enable iterative refinement. Clinical pathways can be adjusted, user interfaces simplified and escalation prompts clarified in response to observed behaviour. Governance processes can also mature, with version control and audit mechanisms tested in live settings.

This incremental learning aligns with NHS commissioning culture, which prioritises safety, evaluation, and measured scaling. Commissioners are rarely persuaded by single-site success stories alone; they seek evidence of reproducibility and controlled evolution.

Framing pilots as infrastructure development rather than marketing milestones shifts expectations. Success is not defined solely by uptake metrics but by improved alignment between system design and practice reality. When expansion follows structured learning, scale becomes an extension of stability rather than a leap of faith.

In community pharmacy, cautious progression is not resistance to innovation. It is a safeguard for sustainable transformation.

8.0 What ICSs and Commissioners Should Consider Before Scaling

For Integrated Care Systems (ICSs) and commissioners, decisions to scale AI-supported consultation tools in community pharmacy should not begin with capability claims, but with clarity.

First, scope must be defined. What clinical pathways are included? Under which frameworks for example, Pharmacy First will the system operate? Is it intended for structured minor ailment consultations only, or does it extend to referral triage and follow-up? Ambiguity at the outset leads to misaligned expectations.

Second, governance architecture should be reviewed before expansion.

Commissioners should seek evidence of override functionality, transparent reasoning logic, version control and clear escalation criteria aligned with national and local guidance. Scaling without tested governance maturity introduces avoidable risk.

Evaluation metrics also require advance definition. Adoption rate alone is insufficient. Meaningful measures may include consultation duration stability, documentation completeness, variability reduction, override patterns, referral appropriateness and user confidence over time. Baseline data gathered during pilots strengthens evaluation.

Pilot duration should be realistic. Short trials demonstrate usability but rarely reveal behavioural adaptation or long-term workflow impact. Time must be allowed for training, feedback and refinement, with structured review points to maintain accountability.

Reporting structures matter equally. Clear responsibilities between pharmacy contractors, digital providers and system leaders reduce uncertainty. Data-sharing expectations, incident reporting and performance review frameworks should be agreed in advance.

A distinction is necessary between partnership-led implementation and transactional procurement. Purchasing software is not equivalent to

embedding infrastructure. Sustainable adoption requires ongoing dialogue between clinicians, developers and commissioners. Feedback loops and governance reviews are core to safe scaling.

Finally, proportionality should guide expansion. Digital maturity varies, and phased rollout can reduce disruption while preserving safety.

For ICSs and commissioners, the question is not whether AI can support consultations, but whether it can do so safely, transparently and sustainably at scale. Careful preparation transforms innovation into dependable infrastructure.

9.0 From Product to Partnership: The Maturing of Digital Health in Pharmacy

Digital health in community pharmacy is moving beyond standalone tools. Early innovation focused on discrete products designed to solve specific workflow problems or digitise isolated processes. While such tools may demonstrate value, they rarely achieve sustained impact without integration into clinical and commissioning ecosystems.

> **"The evolution of structured services such as Pharmacy First within the NHS has accelerated this shift. As community pharmacy assumes a more formalised clinical role, digital support must align not only with individual workflows but with system-level governance, reporting requirements and interoperability expectations."**

This is where the distinction between **product** and **partnership** becomes significant. A **product** can be procured and trialled. A **partnership** involves shared accountability for outcomes. It requires collaboration between pharmacists, developers and commissioners. Feedback loops become continuous. Iteration is expected rather than reactive. Governance is co-developed rather than retrospectively imposed.

In AI-supported consultations, this maturation is particularly important. Clinical pathways evolve, guidance updates and referral networks shift. A static product struggles to keep pace. A 'partnership model' allows systems to adapt alongside service evolution.

There is also a cultural dimension. When pharmacists are treated merely as end-users, adoption may remain superficial. When engaged as co-designers, digital tools are more likely to reflect real practice. This approach strengthens trust and reduces resistance.

Commissioners increasingly recognise that sustainable transformation is less about acquiring technology and more about building capability. Infrastructure thinking prioritising governance, interoperability and long-term support replaces short-term innovation theatre.

The shift from product to partnership signals a broader evolution in pharmacy's digital journey. AI-supported consultation systems are not quick fixes but components of wider infrastructure that must integrate with professional standards and commissioning frameworks.

In this model, success is measured not by novelty but by durability. Digital health in pharmacy matures when collaboration, not capability alone, becomes the foundation of scale.

10.0 Conclusion: Vision Only Matters If It Survives Tuesday Morning

Artificial intelligence will continue to feature prominently in strategic discussions across the National Health Service. The language of transformation, productivity and access will remain persuasive. Community pharmacy, particularly within structured services such as Pharmacy First, sits firmly within that narrative.

Yet strategy alone does not determine success.

AI-supported consultation systems are not tested in conference halls or policy documents. They are tested in routine practice in busy dispensaries, during interrupted assessments, under the pressure

of queue management and professional accountability. The decisive question is not whether a model is impressive, but whether it integrates seamlessly into that reality.

Throughout this discussion, several themes have emerged:

- Workflow compatibility outweighs technical sophistication.
- Governance maturity must precede scale.
- Documentation integrity underpins commissioner confidence.
- Human factors shape adoption more powerfully than feature lists.
- Pilots function best as learning environments rather than promotional milestones.
- Sustainable implementation depends on partnership rather than procurement alone.

Taken together, these principles shift the conversation away from technological optimism toward operational discipline.

"Community pharmacy is evolving into a more formalised clinical environment, with structured pathways and clearer accountability. Digital systems that recognise this shift and respond with restraint, transparency and iterative refinement are more likely to endure. Those that prioritise novelty over integration risk quiet abandonment."

Vision matters, innovation matters but in healthcare, credibility is earned through repetition, safety and reliability. An AI system that performs consistently on a Tuesday morning when staff are stretched and expectations are high contributes more to transformation than one that dazzles in demonstration.

In community pharmacy, the real measure of innovation is whether it can stand up to everyday use.

Building a sustainable medicines CIP and transformation programme at London North West University Healthcare NHS Trust

Author:

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About the author

Aarti Patel is the Lead Pharmacist for Transformation at London North West University Healthcare NHS Trust. She was appointed to establish and lead a Trust-wide Medicines Management Transformation Programme, providing strategic oversight of medicines-related cost improvement programmes (CIPs) alongside quality, sustainability and patient-centred transformation. Her role spans clinical engagement, financial governance, programme management and system working across North West London. Aarti works closely with pharmacy, finance, clinical and transformation colleagues to embed robust benefit tracking, support cultural change and build a sustainable, multi-year pipeline of medicines optimisation initiatives. Her professional interests include medicines value, reducing unwarranted variation, sustainability and developing pharmacy leadership capability within large acute organisations.

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Introduction

Medicines represent one of the largest areas of clinical expenditure within NHS provider organisations, while also being central to patient outcomes, experience and safety. For many trusts, medicines-related cost improvement programmes (CIPs) have historically been delivered in a fragmented way, often driven by short-term financial pressure rather than long-term transformation. This approach can unintentionally create duplication, tension between clinical and financial teams, and missed opportunities to align quality improvement with efficiency and sustainability.

At the same time, the operating environment for NHS providers has become increasingly complex. Rising medicines costs, supply challenges, workforce constraints and national productivity expectations require organisations to think differently about how value is delivered. In this context, medicines optimisation is no longer solely a clinical or operational concern; it is a strategic lever for organisational transformation.

At London North West University Healthcare NHS Trust (LNWUH), these challenges were recognised as a strategic risk. Medicines-related efficiencies were being pursued, but without consistent oversight, shared ownership or a clear link to longer-term transformation. In response, the Trust created a dedicated Lead Pharmacist - Transformation role, with a clear remit to establish a single, structured Medicines Management Transformation Programme (MMTP).

The MMTP was designed to bring together medicines-related CIPs, quality improvement and sustainability initiatives within a coherent governance framework. Its aim was not simply to deliver in-year savings, but to embed a more mature, collaborative and clinically credible approach to medicines value. This article describes the rationale, design and outcomes of the MMTP, and highlights practical lessons for pharmacy leaders seeking to lead large-scale transformation through medicines.

The problem: fragmented medicines CIPs and limited system oversight

Medicines CIPs at LNWUH were largely developed and delivered at divisional or departmental level. While many individual initiatives were clinically appropriate and well intentioned, the overall approach lacked consistency and transparency.

> "Divisions were sometimes reluctant to share schemes where the benefits might be realised elsewhere, particularly where financial pressures were felt locally. This could lead to siloed working, duplication of effort and, at times, conflict around target allocation and benefit attribution. From a corporate perspective, confidence in reported savings was reduced, making it harder to plan and invest for the future."

Critically, the absence of a coordinated programme limited the Trust's ability to think beyond a single financial year. Opportunities that required longer-term investment, pathway redesign or system working were harder to progress in an environment dominated by short-term CIP delivery. As medicines spend continued to rise, and national expectations around productivity and sustainability increased, it became clear that a different approach was required.

The Trust therefore recognised the need to move away from a reactive, fragmented model towards one that positioned medicines optimisation as a strategic enabler of transformation, underpinned by strong governance, clinical engagement and robust benefit tracking.

Why pharmacy-led transformation was the right solution

Pharmacy occupies a unique position within provider organisations. Pharmacists and pharmacy teams work at the interface of clinical decision-making, operational delivery and financial stewardship. They understand prescribing behaviour, patient pathways and medicines supply, while also engaging routinely with finance, procurement, commissioners and system partners.

The creation of a Lead Pharmacist for Transformation role at LNWUH provided clear accountability and focus for this agenda. It enabled the Trust to move away from dispersed ownership of medicines CIPs towards a coherent programme with defined governance, standardised tracking and a shared vision. The role was deliberately embedded within both pharmacy leadership structures and the Trust's wider transformation governance, ensuring alignment with corporate priorities and executive oversight.

This approach also aligned with the evolving integrated care environment. As systems increasingly focus on collaboration, productivity and sustainability, medicines optimisation offers a powerful lever for system-level value. By framing the MMTP as a transformation programme rather than a collection of savings schemes, LNWUH positioned pharmacy as a strategic partner in delivering organisational and system objectives.

Designing the Medicines Management Transformation Programme

The MMTP was established in 2023 with a clear remit: to identify, implement and monitor medicines-related efficiency and transformation schemes, while supporting quality improvement, sustainability and system working. A monthly programme board was created, chaired by the Chief Pharmacist and reporting directly into the Trust's executive Transformation Group.

A number of core design principles underpinned the programme:

Single programme oversight was central to the model. Medicines-related CIP targets were pooled into one programme, removing divisional competition and enabling shared ownership of delivery. This created a single forum for agreeing medicines strategy, prioritising opportunities and resolving issues.

Robust benefit tracking was another critical component. Standardised approaches to quantifying, tracking and reporting benefits were developed in partnership with finance colleagues. The Trust's TrakIT project management system was used to support real-time reporting where data allowed, improving transparency and confidence in reported outcomes.

Clinical engagement was prioritised from the outset. Schemes were expected to be clinically led and supported, with pharmacy acting as a facilitator and enabler rather than an enforcer. This helped to ensure that initiatives aligned with patient care and professional standards.

"The pharmacy team received a shout out in transformation group for the amazing delivery of the transformation programme. The leadership and improvement approach on this has been fantastic. Well done!"

Chief Executive Officer, LNWUH

"Promoting medicines optimisation and reducing medicines wastage involve a multifaceted approach. The Lead Pharmacist for Transformation continuously drives resilience and collaboration across healthcare teams."

DTC Secretary & Formulary Lead Pharmacist

"The programme has enabled greater engagement with stakeholders, produced timely implementation plans with thorough monitoring and follow up."

Principal Pharmacist Patient Services, Procurement & IT

"The programme lead has supported various projects within pharmacy. This support is encouraging the pharmacy service to develop further, prioritise patient care and improve patient flow."

Principal Pharmacist, Clinical Services

Finally, the programme focused on pipeline development. Rather than relying on in-year reactive schemes, the MMTP sought to build a multi-year pipeline of opportunities, supporting sustainability and reducing the annual pressure associated with CIP delivery.

Together, these elements created a transparent and supportive structure for decision-making, escalation and executive engagement, enabling the programme to gain momentum quickly.

The role of the Lead Pharmacist for Transformation

A key enabler of the MMTP was the creation of a dedicated Lead Pharmacist for Transformation role. This role provided continuity, focus and capacity that is difficult to achieve when transformation activity is delivered alongside operational responsibilities.

The role encompassed strategic leadership, programme management and relationship-building. It acted as a bridge between pharmacy, finance, clinical services and executive teams, ensuring that medicines optimisation was considered within broader organisational priorities. Importantly, it also provided a single point of accountability for medicines-related transformation, reducing duplication and enabling faster decision-making.

This clarity of leadership was repeatedly cited by stakeholders as a critical success factor.

Key initiatives and outcomes

A wide range of initiatives were delivered through the MMTP, spanning medicines waste reduction, clinical pathway redesign and operational optimisation.

Medicines waste reduction was an early focus, reflecting both the financial and environmental impact of unused medicines. A dedicated waste reduction group brought together stakeholders across three hospital sites within the Trust. Using data analytics, the group identified variation in practice, shared best practice and implemented targeted interventions. This work supported the Trust's sustainability agenda while delivering measurable efficiencies.

Clinical pathway redesign also delivered significant benefits. In rheumatology, the Biologic Reduction by Extending Drug Intervals (BREDI) scheme safely extended injection intervals for stable patients, with careful clinical monitoring. This reduced treatment burden for patients, minimised the risk of adverse effects and delivered financial savings without compromising outcomes.

Similarly, the appropriate use of intravenous paracetamol was embedded beyond an initial supply shortage. With clinical support, prescribing practice was reviewed and protocols were maintained after supply normalised, resulting in a sustained reduction of approximately one third in Trust-wide usage.

Operational initiatives focused on improving the transfer of patients' own medicines. This ensured medicines were available when required, supported patient flow and increased the visibility and impact of pharmacy technicians at ward level. These changes not only delivered efficiencies but also stimulated further ideas for service improvement.

Collectively, the programme delivered cash-releasing savings of £2 million in its first year (86% of target). In year two, 115% of the annual efficiency target was identified by month one, representing a significant improvement in planning, confidence and maturity compared with previous years.

Cultural change and stakeholder engagement

Beyond financial metrics, one of the most significant impacts of the MMTP has been cultural. The establishment of a clear programme and dedicated leadership role reduced tension around target allocation and shifted conversations towards shared objectives and value.

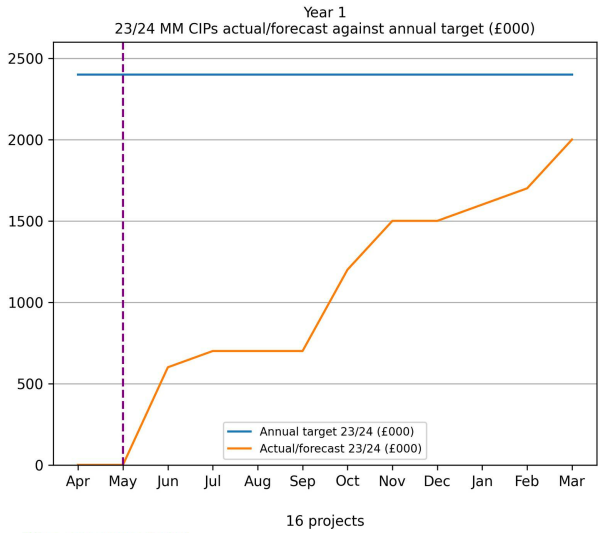
Actively brokering strong relationships between pharmacy, finance and clinical teams enabled more constructive discussions about affordability, variation and opportunity cost. To support this cultural shift, a bespoke six-part Quality Improvement (QI) training programme was delivered within the Pharmacy Department, building practical improvement capability and supporting staff involvement in medicines optimisation and transformation. Rather than viewing medicines CIPs as a purely financial exercise, stakeholders increasingly engaged with them as a mechanism to improve care and sustainability.

Qualitative feedback reflected this shift. Senior leaders highlighted the strength of leadership and improvement approach, while pharmacy and clinical colleagues described improved engagement, prioritisation and follow-up. The programme also demonstrated that large-scale Trust-wide changes could be delivered at pace while maintaining clinical confidence.

Spread and system working

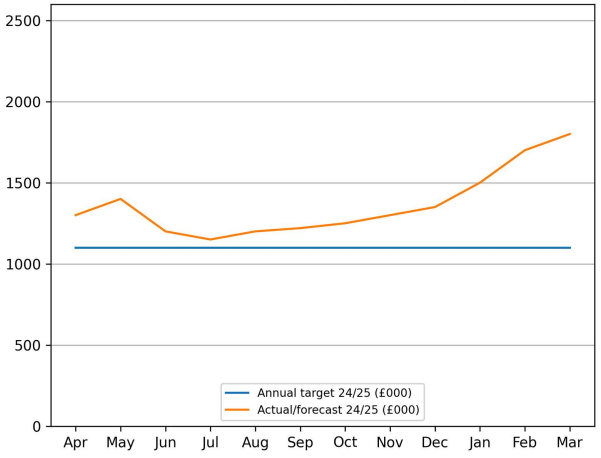
From its inception, the MMTP was designed with spread in mind. Waste reduction approaches were shared across the Acute Provider Collaborative (APC), and elements of the programme were presented at national forums such as the Clinical Pharmacy Congress, generating interest from other organisations.

Financial, governance and operational learning from the programme have been shared widely across North West London, particularly through

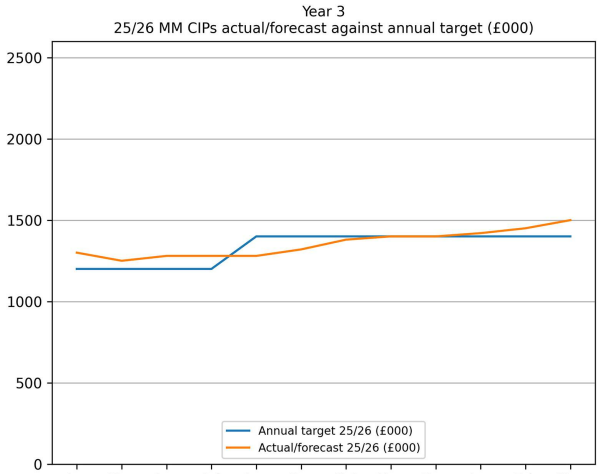


16 projects

-- When programme started



19 projects



39 projects

Year-on-year improvement in medicines cost improvement plan (CIP) delivery following programme implementation

the Medicines Value Group and other system medicines forums. This has supported wider adoption of good practice and strengthened relationships across medicines management forums and productivity groups, reinforcing system-level collaboration.

The governance blueprint developed at LNWUH is now being championed for adoption across other cross-cutting initiatives, demonstrating its applicability beyond pharmacy. Closer collaboration with commissioners has also developed through the programme, particularly in relation to high-cost drugs and ensuring that medicines optimisation work aligns with commissioning and reimbursement arrangements. This system-level engagement has helped align organisational and Integrated Care Board (ICB) priorities, reinforcing the role of pharmacy-led transformation in delivering value across organisational boundaries.

Learning and recommendations: what was changed and what others can do differently

The MMTP has generated a number of important learning points that are transferable to other organisations.

What was changed

The most significant change was the move from fragmented, divisional medicines CIPs to a single, Trust-wide transformation programme. Medicines optimisation was repositioned as a strategic enabler of value rather than an annual financial exercise.

What we learnt

Several lessons emerged. Dedicated leadership and capacity are essential, alongside investment in building practical improvement capability across the workforce.

Pooling targets and schemes reduces internal competition and creates space for collaboration. Robust benefit tracking builds trust with finance and executives, while early and genuine clinical engagement underpins credibility and sustainability. Finally, investing time in culture change pays dividends, enabling more ambitious and longer-term improvement.

What others can do differently

Organisations seeking to replicate this approach should consider creating explicit transformation leadership within pharmacy, with clear executive sponsorship. Establishing a single medicines programme with transparent governance can reduce duplication and conflict. Early partnership with finance is critical, as is a commitment to multi-year pipeline development. Above all, framing medicines optimisation around patient safety, quality and sustainability rather than short-term savings can unlock wider engagement and impact.

Conclusion

The Medicines Management Transformation Programme at London North West University Healthcare NHS Trust demonstrates how pharmacy can lead meaningful, system-aligned transformation. By combining strategic oversight, clinical credibility and robust governance, the programme has delivered over 5.3 million in financial benefits across multiple years since its inception while improving patient care, sustainability and organisational culture.

> "As NHS providers continue to face financial and operational pressures, pharmacy-led transformation offers a powerful mechanism to deliver value-based healthcare. The experience at LNWUH shows that with the right structure, leadership and ambition, medicines optimisation can become a cornerstone of sustainable transformation rather than a recurring annual challenge."

Conflict of interest declaration

The author declares no conflicts of interest.

Optimising High-Cost Medicines: Practical Strategies for Delivering Sustainable NHS Savings

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Janki Patel serves as the Lead Pharmacist for the Medicines Value Programme at East Sussex Healthcare. In this role, she spearheads initiatives to optimise the value and efficiency of medication use within the healthcare system, ensuring that patients receive the best possible care. Before taking on her current position, Janki spent six years as the Lead Pharmacist for Specialist Medicine. During this time, she honed her expertise in various medical specialties, demonstrating a flexible and dynamic approach to meet the diverse needs of specialist medicine services. As an independent prescriber, Janki has the authority to prescribe medications, allowing her to deliver comprehensive and timely patient care. Her extensive experience and commitment to the field of pharmacy have made her a vital asset to her team and the broader healthcare community.

Introduction

Across the NHS, there is increasing pressure to ensure that medicines are used both effectively and sustainably. Medicines optimisation programmes play a critical role in improving patient outcomes by ensuring that patients receive the most appropriate medicines while minimising harm and waste. They also support the responsible stewardship of NHS resources, recognising the significant and growing proportion of healthcare expenditure associated with medicines. Embedding medicines optimisation principles across care settings enables healthcare professionals to deliver high-quality, patient-centred care while maximising the value derived from medicines use (Royal Pharmaceutical Society, 2013; National Institute for Health and Care Excellence, 2015; NHS England, 2015).

Over the past three financial years, the Medicines Value team at East Sussex Healthcare NHS Trust has delivered sustained financial efficiencies while maintaining a strong focus on patient safety and clinical outcomes. Medicines financial efficiency targets are set annually by the pharmacy leadership team and are aligned to the Trust's wider Cost Improvement Programme (CIP). In determining these targets, the team considers projected overspend pressures, opportunities identified through horizon scanning such as biosimilar and generic medicines, and benchmarking against national prescribing data. The Medicines Value team works collaboratively with clinical teams alongside pharmacy procurement and homecare teams to develop and deliver savings schemes, which include formulary optimisation, switching to lower-cost therapeutic alternatives, reducing waste and inappropriate prescribing, and procurement efficiencies. Progress is monitored through monthly finance reports, and the team provides regular updates to pharmacy leadership, ensuring both local and nationally mandated savings schemes are achieved. Through this structured, evidence-informed approach, the team has consistently contributed to cost-effective prescribing while supporting high-quality, patient-centred care.

Financial Year	Target (£)	Actual (£)	Achievement (%)	(£)
2023-2024	594,000	946,674	159	352,674
2024-2025	885,000	1,975,851	223	1,090,851
2025-2026*	503,008	1,496,656	297	993,648

Savings to date

Performance Overview

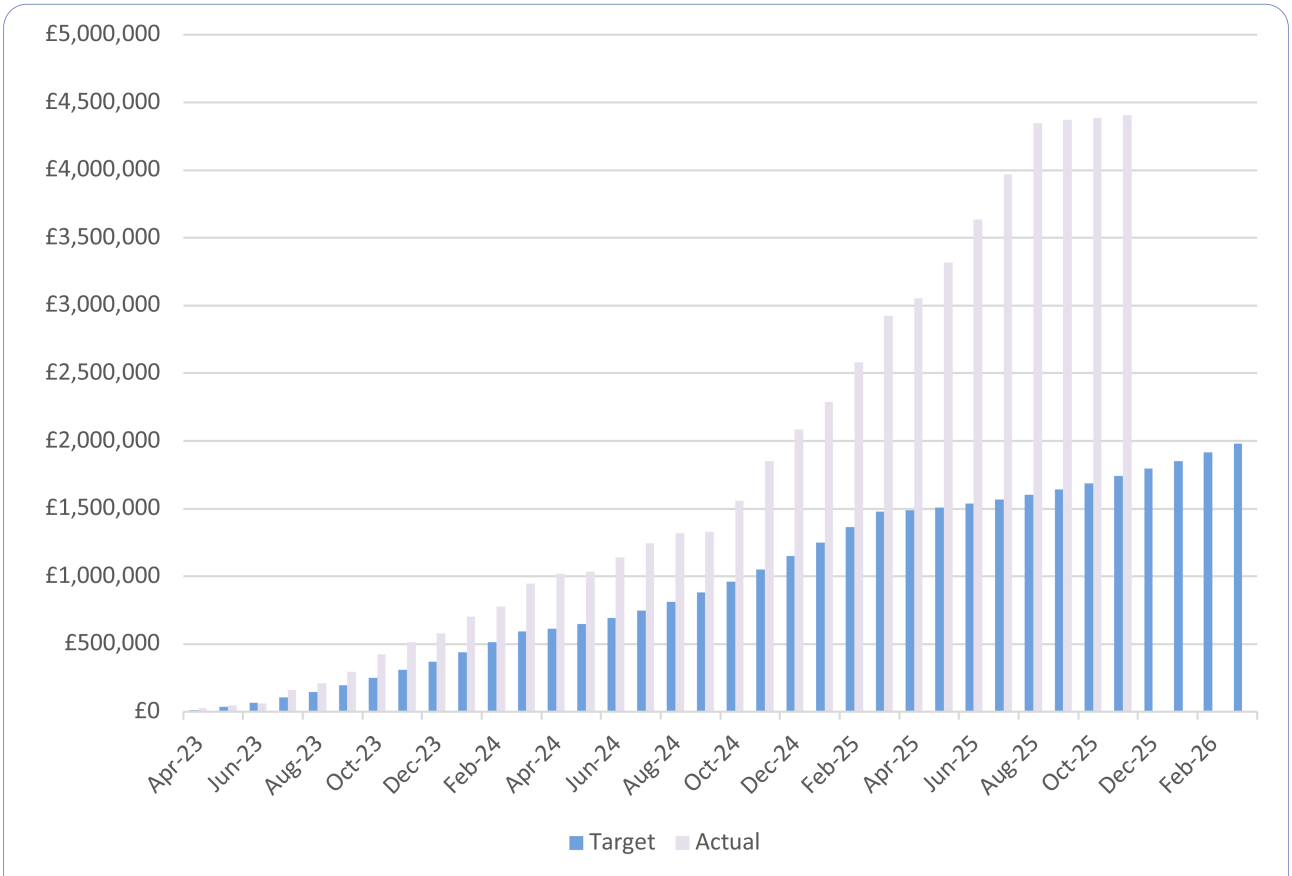
The scale of the impact can be seen through the delivery of savings across three consecutive financial years.

These figures demonstrate a consistent pattern of overachievement, with actual savings exceeding planned targets each year. In 2024–2025, savings more than doubled the original target, while performance in 2025–2026 has continued to exceed expectations.

Target vs Actual Savings

The chart below illustrates the outstanding overachievement by the Medicines Value team over the past three years. Each year, actual savings have significantly exceeded targets, demonstrating the impact of targeted cost-saving interventions:

As the chart shows, the team not only met expectations but consistently delivered savings well beyond planned targets.



MVP cumulative benefit against target

Targeted Medicines Optimisation in Practice

Savings were delivered through a range of targeted medicines optimisation initiatives, focusing particularly on high-cost medicines and opportunities to improve prescribing efficiency while maintaining high standards of care for patients receiving treatments for gastroenterological, neurological, dermatological and rheumatological conditions.

One key area of focus was the ongoing review of patients who remained on originator biologic medicines, particularly those who had previously declined a switch to a biosimilar or had switched back to the originator in the past. These patients were regularly reviewed to assess whether more cost-effective options may now be appropriate based on their current clinical status and the evolving range of available treatments. This approach aligns with current national policy, which emphasises the adoption of best value biological medicines — including biosimilars — where clinically appropriate, recognising that these products are considered **interchangeable with their reference biologic once authorised by the MHRA,** with the potential to generate

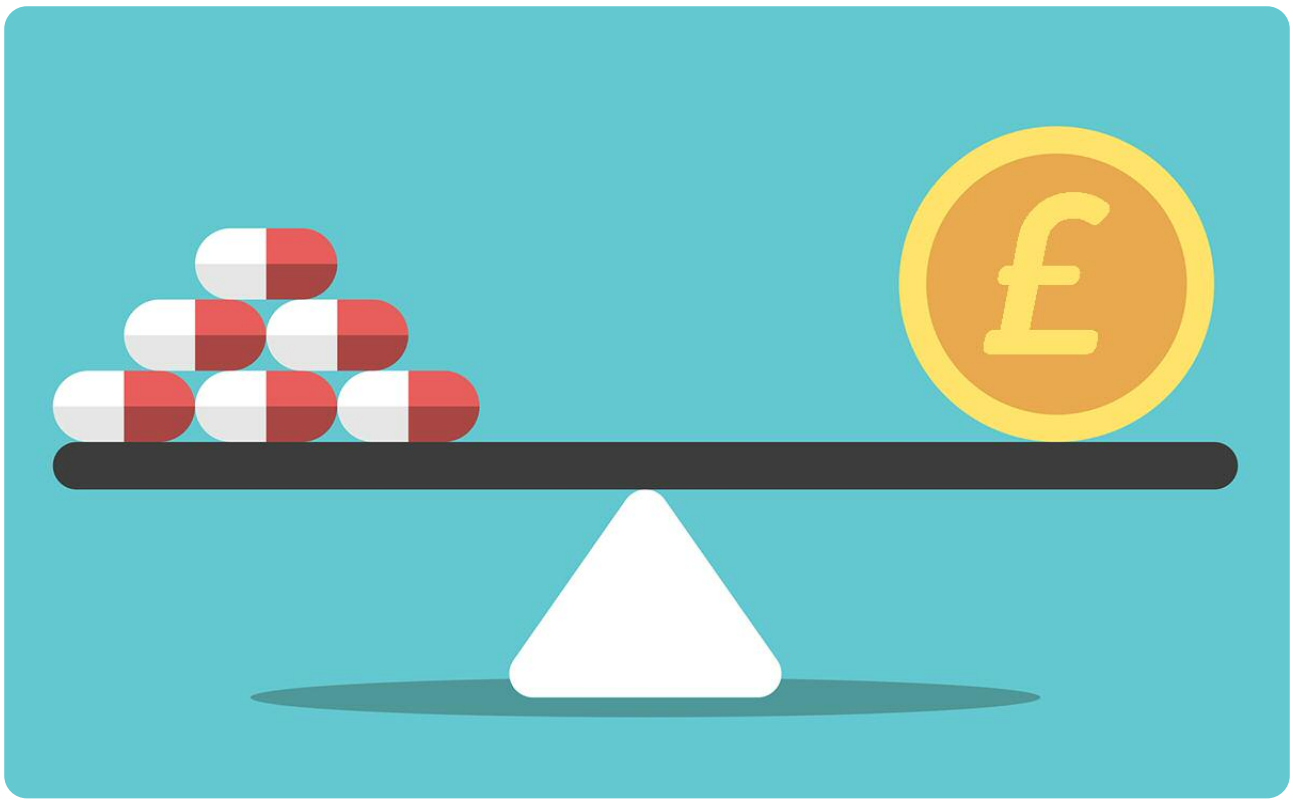
significant efficiencies for the NHS without compromising care. NHS commissioning frameworks support a "best value first" approach, advocating for timely initiation of biological therapy with the most cost-effective option and for consideration of switching existing patients to biosimilars when clinically suitable, always in the context of shared decision-making between clinician and patient.

These reviews were undertaken in close collaboration with clinical teams through ad hoc virtual multidisciplinary team (MDT) meetings, helping to manage the additional workload. The proposals for these MDTs were discussed with the clinical teams, who agreed to participate, and the Trust's general managers were kept informed. No additional funding or staff resources were allocated for these meetings; they were delivered within existing workload pressures and considered part of routine operational activity. Patients were monitored carefully, and where there was evidence of disease flare or reduced treatment effectiveness, clinicians were supported to consider alternative therapeutic options. This approach ensured that medicines optimisation decisions remained clinically led, maximised patient outcomes, and identified opportunities to improve the value of care within existing resource constraints.

Improving transparency around medicines costs also proved to be an important driver of change. Historically, many clinicians were not aware of the significant cost differences between therapies. By sharing medicines pricing information and providing prescribing insights, clinicians were better equipped to consider cost alongside clinical effectiveness when making prescribing decisions. While treatment decisions should always be driven by patient clinical outcomes, greater awareness of medicines costs has helped support more informed and sustainable prescribing choices.

The approach to biosimilar switching has also evolved over time. Historically, switches from originator to biosimilar medicines were often implemented as blanket switches. More recently, particularly where switches are managed through homecare providers, patients may be transitioned without a detailed clinical review. For the most recent biosimilar introduction, however, every patient was reviewed in advance of the launch to determine whether the existing therapy remained the most appropriate option.

In many cases, patients had been established on the same biologic medicine for over a decade. With a much broader range of treatment options now available, clinicians were able to consider



alternative therapies that better reflected the patient's current clinical needs. Once a patient's case was reviewed by the virtual multidisciplinary team (MDT), the specialist nurse contacted the patient by telephone to discuss the proposed treatment plan and the rationale for considering a switch to a biosimilar or alternative therapy; where a face-to-face appointment was imminent, the discussion took place then. Patients were engaged in shared decision-making, given clear information about the clinical evidence supporting biosimilar safety and effectiveness, and reassured that support would be provided throughout the treatment journey. This is consistent with published evidence indicating that patients' perceptions of biosimilars and willingness to switch are strongly influenced by the quality of information they receive and by involvement in treatment decisions, with a systematic review reporting that satisfaction with biosimilar treatment is generally high when patients are informed, but that limited knowledge can negatively impact attitudes (Wu et al., 2023). Other research has similarly demonstrated that patient concerns about switching (including perceived risks or uncertainty about effectiveness) can be alleviated through transparent communication and shared decision-making, underlining the importance of clinician-patient dialogue in supporting biosimilar uptake. In our experience, patients expressed confidence in their clinical teams and were always given the option to switch back if clinically indicated or if they experienced unacceptable side effects after a change in therapy. This approach ensured that treatment decisions remained personalised, respected patient preferences, and supported opportunities for more effective and cost-efficient prescribing.

Key Learning for Other Organisations

Several practical approaches contributed to the successful delivery of medicines savings while maintaining a strong focus on patient outcomes:

- **Regularly review patients on high-cost originator biologics.** Patients who may previously have declined a switch or reverted to originator medicines can be revisited as clinical status and treatment options evolve.
- **Work in close partnership with clinical teams.** Collaborative engagement ensures medicines optimisation initiatives remain clinically appropriate and sustainable.
- **Increase transparency around medicines costs.** Sharing pricing information with clinicians can support more informed prescribing decisions alongside clinical considerations.

- **Monitor patient outcomes closely.** Regular monitoring allows clinicians to respond quickly where treatment is ineffective and supports safe optimisation.
- **Use biosimilar transitions as an opportunity to review therapy.** Rather than implementing automatic switches, reviewing each patient can help ensure they remain on the most appropriate treatment.
- **Take advantage of expanding treatment options.** The increasing range of available therapies creates opportunities to review long-term treatment plans and optimise both clinical outcomes and value.

Looking Ahead

As healthcare systems continue to face increasing financial pressures, medicines optimisation will remain a critical component of sustainable healthcare delivery. The experience of the Medicines Value team demonstrates that significant savings can be achieved through a combination of data-driven review, clinical collaboration, and a strong focus on patient-centred care, ensuring that patients remain actively involved in decisions about their treatment and that therapies are tailored to individual clinical needs. Beyond the direct financial impact, these efficiencies create opportunities for the NHS to invest in additional services and innovations, such as expanding clinic capacity, funding specialist pharmacist-led programmes, or supporting service improvement projects that enhance patient outcomes. By embedding medicines optimisation principles into routine practice, organisations can continue to improve prescribing quality, maximise value from medicines, and ensure that patients receive the most appropriate treatments available, while simultaneously creating capacity for new initiatives that further enhance the patient experience and the sustainability of care delivery.

References

Royal Pharmaceutical Society (2013). *Medicines Optimisation: Helping Patients to Make the Most of Medicines.* London: RPS.

National Institute for Health and Care Excellence (2015). *Medicines Optimisation: The Safe and Effective Use of Medicines to Enable the Best Possible Outcomes (NG5).* London: NICE.

NHS England (2015). *Medicines Optimisation: Helping Patients to Make the Most of Medicines.*

Wu Q, Wang Z, Wang X, et al. Patients' perceptions of biosimilars: a systematic review. BioDrugs. 2023;37(6):829-841. DOI:10.1007/s40259-023-00620-7.

Ryan KA, Cohen-Mekelburg S, Baker JA, et al. Public deliberation to assess patient views on biosimilar medication switching for inflammatory bowel disease. BMC Health Serv Res. 2024;24:1209.

When the System Becomes the Trauma: Performance Management, Workplace Culture, and the Pharmacy Professionals Nobody Sees

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About the author

Rachael Lemon is founder of Lemon Aid Coaching & Consulting, specialising in trauma- informed, neuroinclusive leadership for healthcare professionals. An Honorary Member of the Royal College of Pharmacy for distinguished services to pharmacy, her 20+ years of NHS leadership includes the English Pharmacy Board and strategic advisory roles across NHS England, Department of Health, and Royal Colleges. A domestic abuse survivor with specialist training in trauma-informed practice and rape crisis work, she brings both lived and professional expertise to her coaching practice.

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In this article, the second in the series, Rachael Lemon shares her personal experience of abuse and survival, and how pharmacy can implement and improve systems to recognise the signs of trauma and actively promote a supportive and nurturing working environment.

A successful career?

A senior pharmacist. Excellent track record. National board positions. Strategic planning roles. The kind of career that looks successful from the outside.

Then something changes at home: domestic abuse, caring responsibilities, a mental health crisis, or a chronic illness flare.

The signs show up at work: increased sick days, withdrawn in meetings, flinching when people approach from behind, performance slipping, mistakes creeping in.

What happens next determines everything.

Trauma–informed response: 'You've always been excellent at this job. What's changed? Are you okay?'

What actually happens: Documentation. Performance management. Capability proceedings. Managed out.

> **"I've seen this pattern play out repeatedly. In my own experience. In the dozens of pharmacy professionals I have coached. In the women who reach out after reading my work on workplace trauma."**

The high performer doesn't just stop performing without reason. Instead of asking what changed, we document the symptoms and call it accountability.

My story

For 17 years, I lived with domestic abuse while holding senior NHS pharmacy leadership roles.

Nobody at work knew. Not because I was particularly good at hiding it, but because nobody asked the right questions.

When I started showing signs – flinching when someone came up behind me, increased sick days, performance slipping – they didn't ask what was wrong. They documented it for my personnel file.

My partner rang the office 10 times a day. He would show up at my pharmacy counter with ridiculous excuses for being there – 'Can I borrow a pound for a can of Coke?' - just to check that I was actually at work. He'd peer through windows to make sure I was where I said I'd be.

Nobody else's partner did that. But nobody said anything.

I'd put my name down for conferences and social events, then cancel at the last minute. Always had an excuse. Because if I left the house, my dog would be killed. That was the threat. That was my reality.

Work was my only safe space. The one place where I still knew who Rachael was. Where I was valued. Where I was good at something.

Then I lost it.

Not because I was not good at my job. But because my trauma responses made me 'unreliable.' Because my sick days were 'excessive.' Because a new female chief told me I could take a demotion or leave – 'I don't care which.'

She didn't care which. I had just come back from a brain scan. I had just popped into her office to say hello. That conversation ended my NHS career. Ironically, it also saved my life.

But I didn't know that then.

The professional woman's trap

I had everything that should have protected me: university degree, professional qualifications, national board positions, financial independence, clinical expertise.

The system still failed me.

When I tried to disclose what was happening, I was met with: 'You're educated, you should have known better.'

Professional women face unique barriers. We're expected to have it together. We're dismissed when we struggle because: 'Someone like you should be able to handle this.'

Our credentials become weapons used against us rather than resources to support us.

The isolated pharmacy professional

Community pharmacists face particular vulnerabilities: professional isolation (often the only qualified person in the building), no colleagues to debrief with, constant public-facing pressure, nowhere private to regulate after difficult interactions, expected to be, 'on' all day with no psychological safety net.

> **"Hospital pharmacy teams have different challenges: hierarchical structures that silence junior staff, bullying disguised as 'strong leadership', performance cultures that punish humanity, restructuring that removes career progression whilst keeping job descriptions."**

I experienced the latter. Refused a demotion that would have harmed future pharmacy technicians and was pushed out instead.

The racialised experience

The pharmacy professionals who reach out to me – many are women of colour navigating both workplace trauma and systemic racism.

They're told their concerns about discrimination are 'too sensitive.' That they're 'playing the race card.' That if they just worked harder, were more pleasant, less intimidating, they'd be treated better. They're gaslighted into believing their reality is not valid.

And when they try to address it, they face retaliation disguised as 'legitimate management concerns.'

A woman came to me recently who had experienced workplace bullying and racial harassment. HR told her: 'We don't do anything the first time somebody reports something.'

Think about that response. It takes multiple traumatic incidents before someone reaches breaking point and finds courage to speak up. Most people are silently quitting because the pressure impairs their mental wellbeing.

When they finally report, they're told nothing will happen the first time.

That is not a rogue HR representative. That's what happens when policies exist without enforcement mechanisms, without training, without accountability, without understanding intersectionality.

When workplace culture is the trauma

Not all trauma comes from outside work. Sometimes the workplace itself is the source. 'She just has high standards.' 'He's passionate about excellence.' 'That's just how she is.'

These phrases excuse behaviour that would be recognised as bullying if we called it what it was. Shouting at staff in front of patients. Public humiliation during team meetings. Impossible demands followed by criticism when they're not met. Gaslighting when concerns are raised. This is not strong leadership. It is an abuse of power.

Performance management should support staff development. In practice, it is often weaponised against people who are struggling. Particularly those who report discrimination, raise safety concerns, challenge toxic behaviour, get pregnant, need workplace adjustments, or are experiencing trauma at home.

The pattern is predictable: a staff member raises concern or shows signs of struggling, management begins documenting 'performance issues,' formal capability proceedings initiated, the staff member goes on stress leave, is managed out or constructively dismissed. This isn't accountability. This is how organisations silence people and avoid addressing systemic problems.

Healthcare loves the word 'resilience.' We're told to be resilient in the face of unsafe staffing levels,

impossible workloads, bullying management, systemic discrimination, trauma exposure, but with no adequate support.

But resilience is not an individual characteristic to be trained into people. It is a systemic responsibility.

Telling traumatised staff to 'be more resilient' is like telling someone drowning to 'just swim harder' whilst refusing to throw them a life ring.

Your strategic position

You are positioned to do something most organisations are not: build workplace cultures that recognise trauma responses before they become performance management issues.

This is not about lowering standards. This is about understanding that excellent professionals don't suddenly become unreliable without reason. When someone's performance changes, you have a choice. Document symptoms and manage them out. Or ask what changed and provide support.

One approach loses talented professionals. The other transforms workplace culture.

What would actually help?

During the pandemic, NHS England mandated domestic abuse policies across all trusts. Four years later, ask most pharmacy professionals if their workplace has a domestic abuse policy and they will say either: 'I don't know' or: 'Probably, but I've never seen it.'

The policy exists. The protection does not.

What would make a difference?

Train managers to recognise trauma responses. Increased sick days, withdrawal, performance decline: these are symptoms, not character flaws. Managers need training to ask, 'What's changed?' instead of, 'What's wrong with you?'

Create psychological safety for disclosure. People do not disclose workplace concerns because they fear retaliation. And they're right to fear it. Psychological safety means confidential reporting mechanisms that actually work, protection from retaliation in practice not just policy, believing people the first time they report, investigating thoroughly rather than dismissing concerns, and holding perpetrators accountable regardless of their position.

Understand intersectionality. One-size policies fail because people face multiple, intersecting barriers. The Black pharmacist faces different workplace trauma than the white pharmacist. The disabled professional faces different barriers than the able-bodied professional. The immigrant worker faces different vulnerabilities than the UK citizen.

Stop punishing people for struggling. When someone's performance declines, start with compassion not documentation. Ask what has changed in their circumstances. Explore reasonable adjustments. Offer occupational health support. Consider whether the role itself needs redesigning.

"Build genuine support infrastructure. Not just policies that look good on paper. Actual infrastructure: access to trauma-informed counselling, peer support networks, regular check- ins that go beyond, 'Are you okay?', trained mental health first aiders with protected time and ongoing supervision, clear pathways to specialist support."

Address toxic leadership. You can't have a trauma-informed culture whilst tolerating toxic leadership. Leaders who bully, gaslight, discriminate, or abuse power must be held accountable. Not moved sideways. Not promoted. Not protected because, 'they get results.' The results they get come at the cost of staff wellbeing.

The questions to ask

If you are a leader:

- Do you know who is struggling on your team right now?
- When was the last time you asked someone how they are really doing and had time to hear the answer?
- Would your team feel safe disclosing trauma to you?
- What happens in your organisation when someone reports bullying or discrimination?
- Have you ever checked whether your 'high performer' who never takes sick days is actually okay or just terrified to show weakness?

If you are struggling:

- Is your workplace making you ill?
- Are you being performance-managed for trauma responses?
- Is the behaviour you are experiencing actually bullying (even though it's called 'high standards'?)
- Are you being told you're 'too sensitive' when you raise legitimate concerns?
- Would others recognise what you're experiencing as harmful, even if you have normalised it?

What I wish I had known then

I wish I had known that work being my only safe space was itself a red flag. I wish I had known that losing my job would be devastating but also freeing.

I wish I had known that the new female chief who pushed me out was operating from scarcity, not solidarity.

I wish I had known that my hypervigilance, my flinching, my increased sick days – these were trauma responses, not personal failings.

I wish I had known that asking for help is not weakness. That needing support does not make me less professional. That trauma responses are normal reactions to abnormal circumstances.

Most of all, I wish someone had asked: 'You've always been excellent at this. What's changed? Are you okay?'

Your transformation opportunity

Trauma-informed care in pharmacy cannot exist without trauma-informed workplace culture. You cannot ask staff to hold other people's trauma whilst ignoring their own.

You cannot build psychologically safe spaces for patients whilst maintaining psychologically unsafe workplaces.

You cannot create trauma-informed services whilst tolerating traumatising leadership. The opposite of trauma is not happiness, it is connection.

And connection only happens when someone asks, 'What changed? Are you okay?' – and actually stays to hear the answer.

You are positioned to build this. Not because you are superhuman but because you understand the systems from the inside. You know what pharmacy professionals actually face. You have the credibility to advocate for change.

Every gap in current practice is an innovation opportunity. Every policy that exists without implementation is a transformation waiting to happen.

Support resources

- ACAS (Advisory, Conciliation and Arbitration Service): 0300 123 1100
- Citizens Advice: citizensadvice.org.uk
- NHS Practitioner Health: practitionerhealth.nhs.uk
- National Domestic Abuse Helpline: 0808 2000 247

In this series

- *Next article: Building Trauma-Informed Teams – moving from policy to practice in creating genuinely supportive pharmacy environments.*
- *Previous Article (PM Healthcare Journal: Winter 2026 | Issue 15): The Professional's Blind Spot – why trauma-informed care starts with recognising your own trauma responses.*

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