

JOURNAL

Incorporating *The Journal of Pharmacy Management* and *The Journal of Medicines Optimisation*

Autumn 2026 | Issue 18

In this issue:

The views of pharmacy professionals in general practice on the management of patients with Learning Disability

Mike Wilcock, Mere Chong and Francesca Reville

An Information-Driven Transformation of High Cost Drug Administration and Compliance Processes in Ophthalmology

Ben Marks

**Harnessing the Clinical Expertise of Community Pharmacy:
Integrating Community
Pharmacy into a Unified
Primary Care Patient Offer**

Stephen Riley

**Pharmacy Teams as
Gatekeepers for Suicide
Prevention: Implications for
Pharmacy Education and
Workforce Development**

Dr Lisa Edwards

**Leading Through Trauma:
Why One Size Doesn't Fit
All in Pharmacy**

Rachael Lemon



Intended for UK healthcare professionals and other relevant decision makers only.
This is a promotional material developed and funded by GSK.
Adverse event reporting can be found at the bottom of this advert.

GSK

[Click here for Prescribing Information](#)

NUCALA
mepolizumab

With fewer moderate and severe COPD
exacerbations* with Nucala + SoC vs.
SoC only, give your patients

MORE TIME FOR WHAT MATTERS^{1,2}

**Click here to speak with a
GSK representative**

Leads to a GSK promotional webpage

Hypothetical patient

Nucala is indicated as add-on maintenance treatment of adult patients with uncontrolled COPD of an eosinophilic phenotype on a combination of an inhaled corticosteroid (ICS), a long-acting beta₂-agonist (LABA) and a long-acting muscarinic antagonist (LAMA).¹

* Moderate exacerbations defined as exacerbations (worsening of COPD symptoms) requiring treatment with systemic corticosteroids and/or antibiotics. Severe exacerbations defined as those requiring hospitalisation (≥24 hours) or resulting in death. Nucala + SoC, 0.80/year (n=403) vs. placebo + SoC, 1.01/year (n=401) at Weeks 52-104; RR: 0.79 (95% CI: 0.66, 0.94; p=0.01), MATINEE primary endpoint. Mean rate of exacerbations in previous year in the Nucala population: 2.3.^{1,2}
SoC: standard of care was optimised ICS-based COPD maintenance triple therapy (ICS/LABA/LAMA).

Nucala (mepolizumab) + SoC in COPD has been shown to have a tolerability and adverse event profile comparable to placebo + SoC in RCTs^{1,3}

Across the three placebo-controlled studies in patients with COPD, the most commonly reported adverse reactions during treatment were headache (10%), back pain (7%) and arthralgia (5%). Adverse reactions ≥3% with Nucala and more common than placebo across RCTs: Nucala + SoC (n=1,043) Placebo + SoC (n=1,046) respectively: Back pain 7%/6%; Diarrhoea 5%/4%; Cough 5%/4%; Oropharyngeal pain 4%/2%; Urinary tract infection 4%/3%; Pain in extremity 4%/3%.

Herpes zoster: across the 3 COPD trials, 1% Nucala + SoC and 0.7% placebo + SoC.

In the MATINEE 52-week Phase III clinical study, some of the most frequent on-treatment adverse events for Nucala + SoC (n=403) and Placebo + SoC (n=401) were: On-treatment adverse events: Nucala + SoC = 299 (74%); Placebo + SoC = 307 (77%); Any serious adverse event of death: Nucala + SoC = 99 (25%); Placebo + SoC = 112 (28%); On-treatment adverse events leading to withdrawal: Nucala + SoC = 15 (4%); Placebo + SoC = 16 (4%).

SoC: standard of care was optimised ICS-based COPD maintenance triple therapy (ICS/LABA/LAMA).

Abbreviations:

COPD, chronic obstructive pulmonary disease; RCTs, randomised controlled trial; SoC, standard of care.

References:

1. Nucala SmPC. 2. Sciruba FC, et al. N Engl J Med. 2025;392(17):1710-1720. 3. GSK Data on File: REF-312973.

Adverse events should be reported. Reporting forms and information can be found at <https://yellowcard.mhra.gov.uk/> or search for MHRA Yellowcard in the Google Play or Apple App Store. Adverse events should also be reported to GSK on 0800 221 441 or UKSafety@gsk.com.

Editorial	5
John Chater	

Pharmacy

The views of pharmacy professionals in general practice on the management of patients with Learning Disability	7
Mike Wilcock, Mere Chong and Francesca Reville	

Ophthalmology

An Information-Driven Transformation of High Cost Drug Administration and Compliance Processes in Ophthalmology	16
Ben Marks	

Community Pharmacy

Harnessing the Clinical Expertise of Community Pharmacy: Integrating Community Pharmacy into a Unified Primary Care Patient Offer	27
Stephen Riley	

Workforce and Wellbeing

Pharmacy Teams as Gatekeepers for Suicide Prevention: Implications for Pharmacy Education and Workforce Development	38
Dr Lisa Edwards	
Leading Through Trauma: Why One Size Doesn't Fit All in Pharmacy	51
Rachael Lemon	



This educational non promotional webinar is initiated, funded and reviewed by Viatris and intended for UK healthcare professionals only.



CAN COMBINED LIPID AND BLOOD PRESSURE CHECKING IN PRIMARY CARE CONTRIBUTE TO NHS PLAN OBJECTIVES AND IMPROVE PATIENT CARE?

18TH NOVEMBER 2026 | 18:00 - 19:00 GMT

V I R T U A L E V E N T

White Paper Presentation & Live Polling plus expert Panel Discussion & Interactive Q&A



MERCEDE PANNOZZO

Senior Medical Advisor
- Viatris UK



MARK BURDON

Community Pharmacist
and Lead for the Blood
Pressure and Lipid
Testing Pilot



Click here to book your **FREE** place

Editorial

As we enter Keats' season of mists and mellow fruitfulness, or autumn as we more prosaically call it, we bring you five varied and thought-provoking articles covering a range of issues relevant to pharmacy practice and leadership.

Mike Wilcox et al. examine the views of pharmacy professionals working in general practice on the management of patients with intellectual disability.

Dr Lisa Edwards explores the implications for pharmacy education and workforce development as pharmacy teams take on an increasingly important role as gatekeepers for suicide prevention.

Turning to the integration of community pharmacy into primary care, Steve Riley considers how a unified patient offer could help harness the profession's clinical expertise.

Ben Marks takes a close look at how information-driven transformation can improve the administration of high-cost drugs and support compliance in ophthalmology.

Finally, in the fourth article in her series, Rachael Lemon provides insights into leading through trauma, exploring intersectionality and the development of survivor-led solutions in pharmacy leadership.

As ever, our aim 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, we would be delighted to hear from you.

Read the latest issue of the *Journal* here: <https://www.pmhealthcare.co.uk/journals/>



John Chater

Editor – PM Healthcare Journal

E: editor@pmpublications.co.uk





The views of pharmacy professionals in general practice on the management of patients with Learning Disability

Authors

Mike Wilcock,¹ Mere Chong,² and Francesca Reville³

1 Royal Cornwall Hospitals NHS Trust, Truro, Cornwall

2 NHS Cornwall & IoS ICB, Chy Trewail, Bodmin, Cornwall

3 Health Innovation South West, Exeter, Devon

Introduction

Intellectual disability, also called Learning Disability, is a neurodevelopmental disorder characterised by significant limitations in intellectual functioning and adaptive behaviour, with onset during the developmental period.¹ The prevalence of people with a learning disability in the UK is estimated to be around 1.5 million.² The actual number of people recorded on GP learning disability registers is lower because not everyone has a formal diagnosis or is included on a register.

In the UK, people with a learning disability tend to live either in family settings and/or in their own homes often with the support of private sector care providers, or in 24/7 staffed supported living settings or residential arrangements. General support is funded by the local authority. Medical provision is overseen by the General Practitioner (GP). A referral from the GP to the specialist learning disability health teams would be made if the person's health concerns are outside of other health services and/or if there are challenges for the person accessing those services. These criteria are commonly set within each local area. When involved, specialist learning disability teams typically look to understand the change in biopsychosocial needs for the person and how their learning disabilities may be impacting upon this and will decide on appropriate evidence-based interventions and management/treatment strategies. These would typically range from recommendation of change in social setting and/or occupation and routine to training staff to directly deliver adapted therapies with pharmacotherapy as a later consideration.

People with a learning disability experience significant health inequalities and, compared with their non-disabled peers, they experience increased rates of a wide range of physical health conditions, particularly epilepsy.³ It is relatively common for people with a learning disability to demonstrate behaviours that may be deemed challenging to others. This behaviour often indicates an unmet need in an individual. In this context, it has been described as behaviour which puts an individual or others at risk in any social situation and limits access to and use of ordinary community facilities. National Institute for Health and Care Excellence (NICE) guidance advises that specialists consider prescribing psychotropic medication (including antipsychotics, antidepressants, mood stabilisers and sedatives) to manage behaviour that challenges to people with a learning disability only in specific circumstances.⁴ Though psychotropic medications, particularly antipsychotics, are commonly prescribed to people with a learning disability for behaviours deemed challenging,⁵ there is robust evidence that such prescribing could cause adverse physical health outcomes especially if not monitored regularly. NICE Guidelines have attempted to address the need for antipsychotics and safeguarding from their side effects by ensuring that medication reviews are regular to ensure effectiveness, dose minimisation and causing no harm. Furthermore, NICE recommends that people with a learning disability... [should] only receive antipsychotic medication as part of treatment that includes psychosocial interventions.⁴

Typically, such psychotropic drug use often starts at a specialist level which is then passed





onto primary care with or without specialist follow up. Patients are likely to be discharged from specialist services once their referred health need is met. Hence, many primary care staff are overseeing the management and prescribing of these drugs long term. However, due to the low prevalence of learning disabilities in the general population, there is variation in the levels of primary care expertise in dealing with and supporting patients with a learning disability. Good prescribing practice guidance is available, aimed at primary and secondary healthcare clinicians, proposing standards for improving clinical practice in this area,⁶ and the main aim of the NHS England STOMP (Stopping Over-Medication of People with a Learning Disability) campaign is to support the safe and appropriate use of antipsychotic medicines in people with a learning disability or autism or both.⁷ Despite this, there has been limited decrease in the rates of prescribing of antipsychotics to adult patients with a learning disability without a severe mental illness since STOMP was launched in 2016.⁸

Though some aspects of general practice management of patients with a learning disability have been reported in the literature,^{9,10,11} there is little published research looking at the role of pharmacy professionals working in general practice. One review identified limited evidence suggesting that pharmacists can make positive interventions in relation to the quality of the medication use process, in collaboration with other healthcare professionals, carers and patients with a learning disability.¹² However, of the eight articles included, none related to pharmacy professionals in a general practice setting. One 2022 survey of pharmacists who reviewed psychotropic medication for individuals with a learning disability found that positive attitudes and working in secondary care were associated with greater deprescribing confidence.¹³ However, in this survey only 29 of 83 respondents were working in primary care.

The Health Innovation Network (HIN), under the NHS England Medicines Safety Programme,¹⁴ has a focus on helping people with a learning disability, at risk of behaviour that challenges, to avoid harm from psychotropic medicines. Working with selected Integrated Care Systems across England, the local HINs aim to bring together NHS



providers, social care, voluntary sector and lived experience groups to help people with a learning disability, to avoid harm from psychotropic medicines.¹⁵

The aim of this study was to survey the knowledge level of a sample of pharmacy professionals in one Integrated Care Board (ICB) in relation to learning disabilities. The Cornwall GP Pharmacy Forum was established in 2023 as a novel initiative to develop a 'community of practice' and provide cross sector learning, peer networking, and development opportunities. The Cornwall GP Pharmacy Forum meets quarterly, with a mission statement of: "Forming a non-judgemental local learning community within the Cornwall GP pharmacy workforce, facilitating networking and development opportunities, sharing good practice, encouraging consistency and continuity in working methods." Sessions are divided into clinical CPD updates, tabletop workshops and peer networking. The agenda for forum meetings are co-produced by attendees supported by the forum organisers who are funded by Kernow Health Community Interest Company.

Methods

The questionnaire was developed through discussion between a learning disability clinical specialist, a primary care pharmacist and senior primary-secondary care interface pharmacist. The questionnaire was comprised of 10 questions divided into categories. Questions assessed knowledge of learning disabilities and factors that may lead to behaviour that challenges. Questions aimed to understand current pharmacy team involvement and engagement with medication reviews in people with a learning disability, a free-text optional question to record barriers encountered with medication reviews and a priority ranking of perceived harms of psychotropic medication categories (e.g. antipsychotics, antiepileptics, benzodiazepines). The only demographic details recorded were their professional status and length of GP practice; otherwise the survey was anonymous. Analysis of data was performed using Microsoft Excel. Descriptive statistics were used to describe and summarise the data highlighting the main elements of the study.

Ethics

No ethical permission was required as this was a survey to evaluate knowledge and training. Further it was to a group of pharmacy professionals where consent was implicit by returning the survey form. All participants were advised at the start of the survey that participation was voluntary and their replies, i.e. data would be anonymised and analysed. We also used the NHS Health research authority tool (<http://www.hra-decisiontools.org.uk/research/index.html>) which helped confirm that no ethics is needed for this project.

Results

"There are 55 GP surgeries and 15 Primary Care Networks (PCNs) within NHS Cornwall and Isles of Scilly ICB. Completed questionnaires were returned from 28 of 31 (90%) attendees, consisting of 12 pharmacists (including trainees) and 16 pharmacy technicians (including trainees). The mean duration of working in general practice for 27 of the respondents was 5 years, range 1 to 20 years. No other respondent characteristics were recorded."

As regards to knowledge of associated co-morbidities, most respondents correctly answered 4 out of the 5 questions posed (Table 1). Recognition of the association between learning disabilities and substance misuse was lower, with 50% of respondents answering correctly. Respondents demonstrated greater knowledge when identifying common health problems associated with challenging behaviour in people with a learning disability (Table 2).



	Correct answer	Correct responses N (%)
Less likely than the general population to develop schizophrenia	False	24 (86%)
Less likely than the general population to develop depression	False	22 (79%)
More likely than the general population to develop major mental illnesses	True	21 (75%)
Less likely than the general population to have epilepsy	False	26 (93%)
More likely than the general population to develop substance misuse disorders	False	14 (50%)

Table 1 - True or false questions about perception of people with learning disabilities

	Correct answer	Correct responses N (%)
Constipation	True	25 (89%)
Severe earache	True	24 (86%)
Depression	True	25 (89%)
Bereavement	True	23 (82%)
Dementia	True	24 (86%)

Table 2 - True or false questions about which of these common physical health concerns could predispose to challenging behaviour in people with learning disabilities

When asked if within their GP practice, there is a named STOMP/STAMP (Supporting Treatment and Appropriate Medication in Paediatrics) or learning disability champion, 11 replied yes, 3 replied no, and 14 were unsure. For the question asking if within their GP practice, patients with a learning disability are able to book longer clinic appointment times, 25 answered yes, 1 answered no, and 2 were unsure.

As regards who generally undertakes Structured Medication Reviews (SMRs) for patients with a learning disability, 10 replied a GP and a pharmacist, 8 a GP, 8 a pharmacist, and in two instances the respondents were unsure. One question noted that there are various

professional resources for patients with a learning disability linked to safe prescribing and deprescribing practice and asked to what extent they perceived these resources being used in their GP practice: 12 respondents were unaware of these resources being used, 4 replied they are rarely or never used, 9 that they are used occasionally and 2 that they are used consistently. Twenty-seven attendees responded to being asked to what extent does the pharmacy team in the GP practice help trigger referrals to specialist/secondary care for consideration of STOMP/STAMP prescribing issues: 2 replied they try to make this happen consistently when needed, 6 that this happens occasionally, 5 that this does not happen, and 14 were unsure.



As regards the statement “In my GP practice, I feel that patients with learning disabilities have access to appropriate non-pharmacological support.” 6 said access could be improved, 6 said access is adequate or good, 14 were unsure, and 2 did not reply. When asked if they encounter specific challenges when implementing STOMP/STAMP reviews or initiatives in their practice, 4 replied yes, 4 no, 19 were unsure, and one did not reply.

“When asked to rank the following psychotropic medicine groups from 1 to 6, where 1 is the highest priority to review (the most important for reducing patient harm) and 6 is the lowest priority to review, the ranking is shown below. In order of the ranking, “Combinations of psychotropics” were the majority’s first choice for harm ranking, followed by benzodiazepines, antipsychotics, hypnotics and Z-drugs, antiepileptics and antidepressants. For this question, there were 26 responses out of the 28 respondents.”

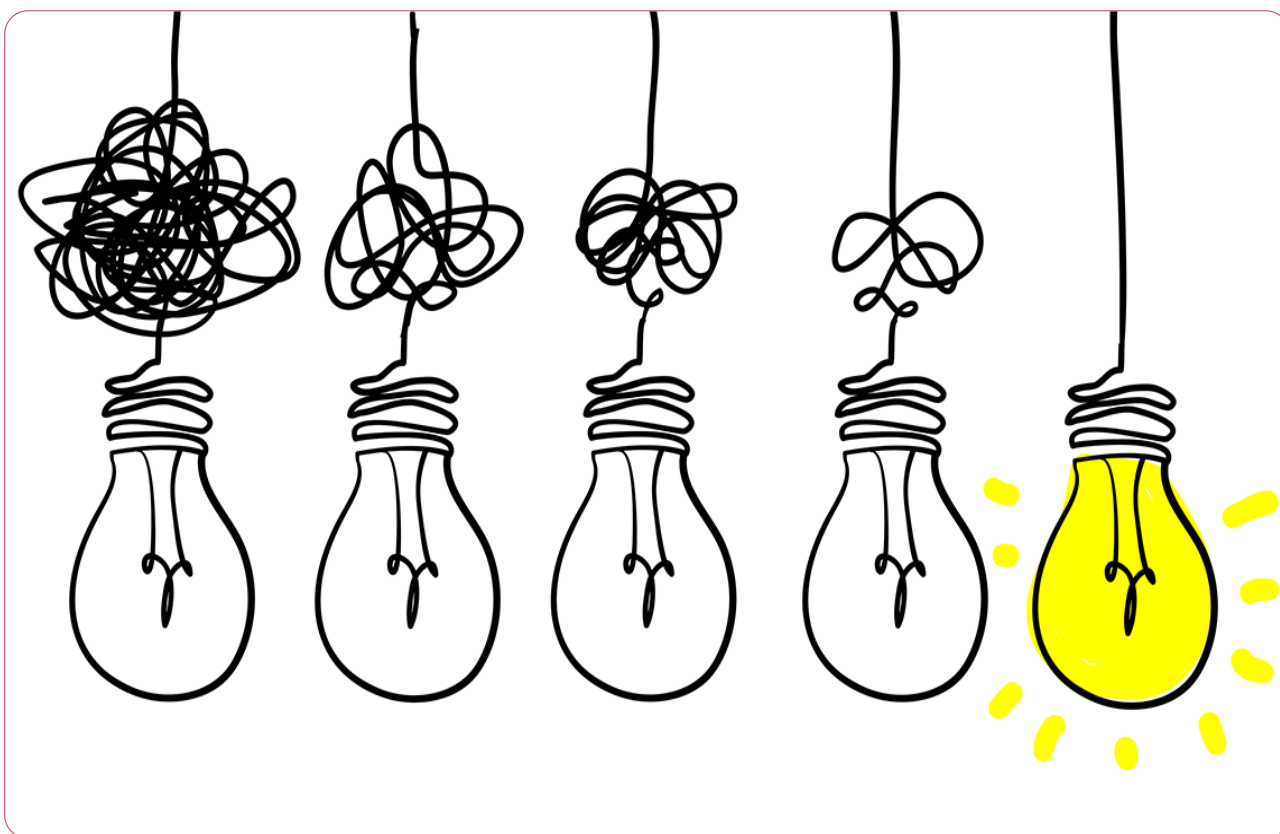
Discussion

The results of this small study have shown that a sample of pharmacy professionals working in general practice across the ICB appear to have a reasonable knowledge of some aspects of learning disabilities. The area where correct responses were less than 75%, related to knowledge of the association between learning disabilities and wider substance misuse (e.g. alcohol). Lower levels of awareness of this specific issue were also observed in a similar previous survey of GPs working across Cornwall & the IoS.¹⁶

Inappropriate prescribing and monitoring of side effects of antipsychotic medication for people with a learning disability has been well described.^{17,18} One of the initial resources associated with the national campaign urged GPs to undertake a number of steps, including appointing a GP lead for learning disabilities.¹⁹ More recently, practices have been encouraged to have a champion for learning disabilities.²⁰ We noted that in this survey, 11 replied they have a named learning disabilities champion, though we do not know if this is a GP or other member of the practice staff. Interestingly, 2 of these 11 did not know of the various resources^{21,22,23} for patients with a learning disability linked to safe prescribing and deprescribing practice, 4 said they were rarely or never used and 4 used occasionally. One of the 11 did not answer this question. A high proportion of respondents (89%) reported that patients with a learning disability are able to book longer clinic appointment times, consistent with the duties of making reasonable adjustments for disabled people.²⁴

Responses relating to the implementation issues associated with the STOMP/STAMP initiative were characterised by a high proportion of unsure





answers. Fourteen of the 28 attendees were unsure of the extent to which the pharmacy team helps trigger referrals to specialist/secondary care for consideration of STOMP/STAMP prescribing issues, and 19 were unsure if they encounter specific challenges when implementing STOMP/STAMP reviews or initiatives in their practice. It is therefore difficult to draw firm conclusions from those that gave a definite answer to these two questions. The STOMP and STAMP standards require a focus on delivering quality SMRs by practitioners who are fully informed of the needs of people with a learning disability and autistic people. We note that the pharmacist survey from 2020 revealed that the most frequently reported key enablers for deprescribing psychotropic medicines were effective collaboration between primary and secondary healthcare settings, along with robust communication and positive relationships among stakeholders.¹³ This is to some extent reflected in the free-text response from the four respondents who replied that they do have specific challenges when implementing STOMP/STAMP reviews or initiatives. These challenges were around patients not fitting the criteria to access support/specialist services; the challenge of multi-disciplinary team working and communication; the difficulty of review without good secondary care

involvement; the time required to check understanding of the review process, and a suggestion of the carer involvement swaying the review process. These have been identified previously by nonpsychiatrist participants in a survey of psychiatrists and non-psychiatrists' attitudes to psychotropic optimisation for people with a learning disability in which pharmacy staff who work with people with a learning disability made up 13% of the survey participants.²⁵

We recognise the limitations with this small study undertaken in just one ICB with a selfselected group of pharmacy professionals. We also used a survey which could have introduced biases such as recall bias and answering tendencies. Furthermore, possibly multiple personnel from the same GP practice/PCN may have responded.

Conclusion

There is little published evidence available to inform how pharmacy professionals in a general practice setting can better support patients with a learning disability in relation to their medicines. This survey was undertaken to inform the work programme of the National Medicines Safety Improvement Programme and to explore current



knowledge and perceptions within the primary care pharmacy workforce. The findings highlight some gaps in understanding and awareness of how people with a learning disability are supported and managed within general practice settings across Cornwall. Looking ahead, there is an opportunity to repeat this survey across a wider geography, particularly as the Cornwall and Devon ICBs work more closely together and given Devon's involvement in the programme through a separate workstream. The findings could also be used to inform targeted education and professional development activities where required.

"The authors plan to have an awareness-raising discussion with the GP Pharmacy Forum about the services provided by the community learning disability team, and the support available to primary care colleagues. In addition, we intend to follow up with a number of respondents, to gain a fuller understanding of their involvement in STOMP/STAMP-related work within primary 'practice and explore opportunities for wider learning and knowledge sharing."

References

- 1 American Psychiatric Association. DSM-5 Task Force. *Diagnostic and Statistical Manual of Mental Disorders* 5th ed. American Psychiatric Publishing, 2013.
- 2 <https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/how-common-learning-disability> (Accessed 18/09/26)
- 3 Sun JJ, Perera B, Henley W, et al. Epilepsy related multimorbidity, polypharmacy and risks in adults with intellectual disabilities: A national study. *J Neurol* 2022;269(5): 2750–2760.
- 4 NICE. *Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges*. NG 11, 2015.
- 5 Gorman A, Odalović M, Paul A, et al. Changing Patterns of Psychotropics Use Among Older Adults With Intellectual Disability Over a Decade, With a Focus on Designated Mental Health Conditions. *J Appl Res Intellect Disabil* 2026;39(1): e70182
- 6 Faculty of Psychiatry of Intellectual Disability. *Psychotropic drug prescribing for people with intellectual disability, mental health problems and/or behaviours that challenge: practice guidelines*. The Royal College of Psychiatrists. 2016.
- 7 NHS England. *Stopping over Medication of People with Learning Disabilities*. 2016. www.england.nhs.uk/learning-disabilities/improving-health/stomp
- 8 <https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2024-to-2025> (Accessed 30/07/26)
- 9 Shea B, Bailie J, Dykgraaf SH, et al. Access to general practice for people with intellectual disability in Australia: a systematic scoping review. *BMC Primary Care* 2022; 23:306
- 10 Bakker-van Gijssel E, Olde Hartman T, Lucassen P, et al. GPs' opinions of health assessment instruments for people with intellectual disabilities: a qualitative study. *Br J Gen Pract* 2017;67:e41-e48.
- 11 Russell A, Bryant L, House A. Identifying people with a learning disability: an advanced search for general practice. *Br J Gen Pract* 2017;67:e842-e850.
- 12 O'Dwyer M, Meštrović A, Henman M. Pharmacists' medicines-related interventions for people with intellectual disabilities: a narrative review. *Int J Clin Pharm* 2015;37:566–578.
- 13 Adams D, Hastings RP, Maidment I, et al. Pharmacists' Perspectives on Deprescribing Psychotropic Medicines in People with Intellectual Disabilities. *Journal of Mental Health Research in Intellectual Disabilities* 2026;19(1):23–42.
- 14 NHS England. *The National Patient Safety Improvement Programmes*. <https://www.england.nhs.uk/patient-safety/patient-safety-improvement-programmes/#MedSIP> (Accessed 30/07/26)
- 15 Health Innovation Network. *Medicines Safety*. <https://thehealthinnovationnetwork.co.uk/programmes/patient-safety/medicines-polypharmacy/medicines-safety/> (Accessed 30/07/26)



- 16 Shankar R, Wilcock M. Improving knowledge of psychotropic prescribing in people with Intellectual Disability in primary care. *PLoS ONE* 2018;13(9):e0204178.
- 17 Alexander R, Shankar R, Cooper S, et al. Challenges and pitfalls of antipsychotic prescribing in people with learning disability. *Br J Gen Pract* 2017;67:372-373.
- 18 Marquis S, O'Leary R, Marquis NE, et al. A Rapid Mapping Review of Medication Burden in Adults with an Intellectual Disability: What We Know and What We Do Not Know. *Drug Healthc Patient Saf* 2026;18:558001
- 19 NHS England. *Stopping Over-Medication of People with a Learning Disability, Autism or Both (STOMP)*. 2017. <https://www.england.nhs.uk/wp-content/uploads/2017/07/stomp-gp-prescribing-v17.pdf> (Accessed 30/07/26)
- 20 Royal College of General Practitioners. *Do you see me? Improving health for people with learning disabilities*. <https://www.rcgp.org.uk/Blog/Learning-disabilities> (Accessed 30/07/26)
- 21 Royal College of Psychiatrists. *Stopping the overmedication of people with intellectual disability, autism or both (STOMP) and supporting treatment and appropriate medication in paediatrics (STAMP)*. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/position-statement-ps0521-stomp-stamp.pdf?sfvrsn=684d09b3_8 (Accessed 30/07/26)
- 22 Royal College of Pharmacy. *Learning disability and autism awareness*. <https://www.rcpharm.org/pharmacy-guides/learning-disability-and-autism-awareness/#h-medication-reviews> (Accessed 30/07/26)
- 23 PrescQIPP. *Stopping over-medication of psychotropic drugs*. PrescQIPP January 2025.
- 24 NHS England. *Reasonable adjustments*. <https://www.england.nhs.uk/learning-disabilities/improving-health/reasonable-adjustments/> (Accessed 30/07/26)
- 25 Tromans SJ, Deb S, Mahmood H, et al. Psychiatrists and non-psychiatrists' attitudes to psychotropic optimisation for people with intellectual disabilities and/or autism: crosssectional comparison study. *BJPsych Open* 2025;11(6):e249.





An Information-Driven Transformation of High Cost Drug Administration and Compliance Processes in Ophthalmology



Ben Marks,

Lead Pharmacist, Ophthalmology, Buckinghamshire Healthcare NHS Trust

About the author

I am a Speciality Lead Pharmacist for Ophthalmology for an NHS Trust, who seeks and enjoys the challenges of service improvement. Previously, I have worked as a Principal Healthcare Consultant at a London-based analytics and consultancy firm, focussing on transforming data into actionable business intelligence, and the engaged improvement and opportunity journey. I have worked on several GIRFT projects and speciality reports and many other NHS, CQC, health improvement and transformation projects in healthcare and defence. I also carry subject matter expertise in Medicine, Medicines Optimisation, Clinical Trials and Oncology.

Introduction

Ophthalmology is now the busiest NHS speciality in secondary care, making up 10% of waiting times.¹ and seeing more than 9.6 million patients a year in 2024/25.² Services are typically capacity constrained; operating at near or effective full capacity, which places significant demand on patient pathways and clinical staff. Medical Retina, the subspecialty concerned with surveillance and treatment of retinal disease, is a key high-volume high-cost healthcare resource consumer for the speciality and wider NHS. The three main disease cohorts are Age related Macular Degeneration (AMD), Diabetic Macular Oedema (DMO) and Retinal Vein Occlusion (RVO). Typical Trust units may use millions of pounds worth of 'High Cost Drugs' (HCD) a year, across thousands of patients.

The drugs used (intravitreal anti-VEGF biologics and steroids) to treat retinal disease have become so effective at preserving vision that management of these pathologies has become analogous to

other long-term conditions. The result is that pathways in Medical Retina have known national capacity issues, with the GIRFT programme citing the need for more capacity and productivity in their 2019 National Speciality Report for Ophthalmology.³ This report also acknowledged the intense demand and predicted a 50% demand increase in the following 20 years. In addition, the Royal College of Ophthalmologists reported in 2023 that most ophthalmology services are facing significant capacity issues, with 76% not having enough consultants to meet current demand.⁴ Therefore, any medicines, pathways, process or service optimisations that can deliver real quantitative impact are likely to be opportunities to consider in terms of their potential value to patients, clinicians, providers and commissioners.

This article presents the outcomes of several optimisations made to the way Medical Retina uses data to leverage productivity improvements across the patient pathway and financial and administrative reporting and compliance functions. These benefits have been identified by looking at the key people, systems and processes in this part of the organisation and using some of the principles from 'Lean Production' theories for process improvement, performance and quality control.^{4,5}

The historical problem and aims of this project

High-Cost Drugs are reimbursed via an NHS England (NHSE) database and clinical validation system known as 'Blueteq' in a significant number of healthcare systems in England. This requires the Trust to apply for funding for each drug and patient eye at treatment initiation and therapeutic change. The data is used by the relevant regional



Commissioner (the Integrated Care Board (ICB)) who reimburse providers for HCD costs accordingly. Other IT systems in use at speciality or trust level exist as discrete, unconnected or partially connected software, with staff in the patient pathways being required to ensure data entry is completed across this clinical software.

A typical process in Medical Retina starts when an Ophthalmologist diagnoses a retinal pathology and plans treatment with regard to NICE guidance. Historically, the doctor would complete a paper form detailing the indication and treatment and send these to Pharmacy for clinical review and submission to the ICB. A key process change occurred with the introduction of a new Electronic records and Medicines Administration (EMA) system, which saw the completion of the Blueteq HCD work by the Ophthalmologist during, between or after consultations. Although this eliminated the significant paper burden, it introduced requirements for extremely busy, highly trained clinicians to undertake increasing volumes of work that could be transferred to administrative role types.

Although necessary and contractual for Trust reimbursement, the value of this HCD process to the patient, and clinician could be zero or even negative, because it reduces Ophthalmologist patient contact time. Unsurprisingly, the completion rates of the forms necessary for reimbursement were highly variable and unpopular. Several focus areas arose.

Increasingly, the Commissioner requirement for improved accountability around HCD compliance provided a mandate to develop repeatable, accurate and data-led processes to provide a high degree of reassurance for all.

"In summary, there was an urgent need for a fully accountable HCD process in Ophthalmology which did not consume patient contact time in the clinic and was tractable and auditable for the large numbers of injected doses given. Improvements to compliance, accountability and capacity were needed."

Pathway analysis

To help overcome and maximise the impact of the issues listed above, a high-level Value Stream Mapping approach derived from the Lean Production domain was used. Specifically, it was used to identify wasted efforts and resources, bottlenecks, avoidable delays and other constraints, and show how these could be mitigated or eliminated.^{6,7}

Issue 1: There was no clinical value to HCD application form completion, but it was essential for Trusts to be reimbursed for medicines used.

Issue 2: The clinical declarations required for remuneration needed to be completed by staff with appropriate clinical knowledge and familiarity.

Issue 3: Existing processes for completing the necessary documentation had failed to manage potential Trust financial risk adequately, with possible large shortfalls in Trust remuneration.

Issue 4: Audit controls for the existing processes may not have been able to provide the information needed to assure the desired reporting quality.



Table 1: Value Stream Analysis

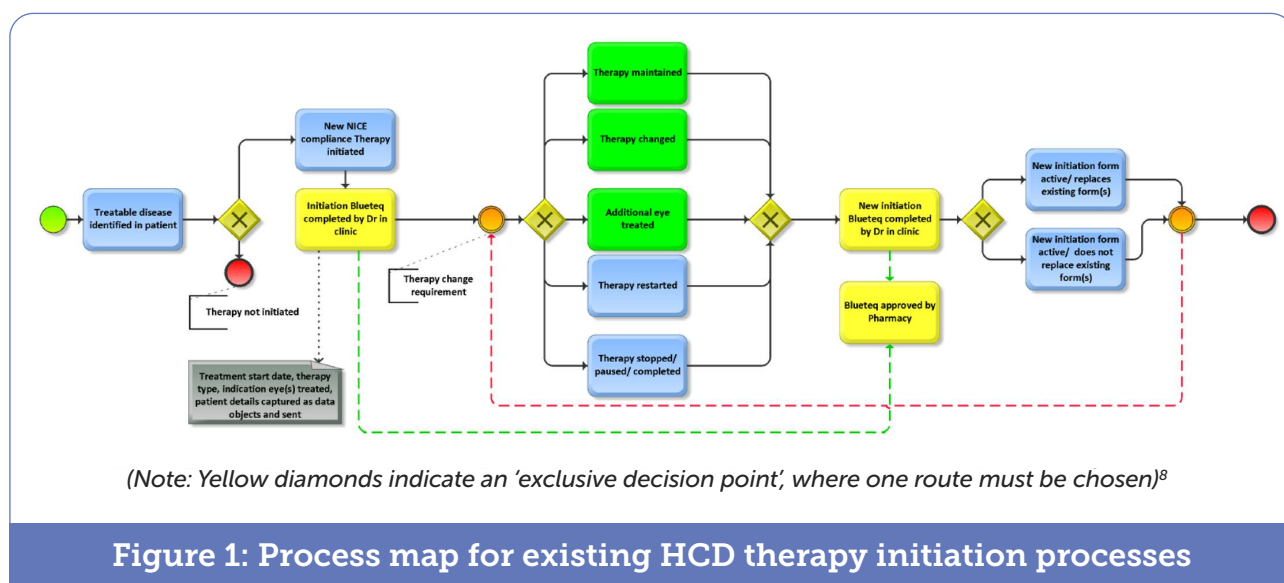
This table lists areas that were specifically considered during this work. Here “value” refers to benefits for the patient (outcomes and experience), clinicians (time and elimination of nonclinical activities), the Trust (costs, revenue and capacity management), and the ICB (improved financial planning and budgetary allocation around NICE approved therapeutics).

ID	Value-adding outcomes	Areas of focus
1	Increase value-creating activity	Maximising patient flow, maximise patient-facing clinical time, maximise capacity.
2	Eliminate non-value creating activity (wasted effort)	Reduce waits, stop undertaking activities in clinic that do not need to be completed face-to-face.
3	Minimise essential non-value creating activity	Make essential administration as efficient as possible.
4	Minimise the number of process steps as far as possible (simplified processes are more efficient, reliable and safe)	Maintain essential clinical aspects and stop doing other things (where possible) in clinics. Minimise distractions.
5	Reduce the time to complete the process steps that comprise the patient pathway	Reduce time to complete processes under investigation (also known as ‘Takt Time’ in Lean Production theory).
6	Reduce the wait times between process steps	Reduce unnecessary waiting time.

The next stage of the review exercise was to apply the principles in Table 1 after a mapping and assessment of the existing process. Of particular interest were the number of process steps and waits, decision points, back-loops, entrance and exit points, and parts of the process that are

candidates for parallelisation.

Figure 1 represents a clinical process that has evolved from an adapted patient pathway to include the systems and processes required to ensure that HCD applications are active at the



point of therapy provision.

There are four decision points:

- The decision to treat or not
- The decision to choose one of five therapy outcomes
- A decision to complete a new HCD application, based on commissioner and national guidelines
- A decision to discontinue or maintain previous applications

There are also a total of six process steps for each treated patient in the pathway, requiring the use of at least two software applications.

An initial spreadsheet, available in 2021, would have indicated that we were approximately 20% - 40% compliant, with respect to Blueteq applications for our drug use over the last 10 years (however this was based on the historic data available and provided).

This analysis provided a snapshot of where we were and where HCD processes needed to move to. This led to a set of requirements.

Above all else, there was a key theme concerning improved access and management of data, which could form the basis of a new process and administrative function, and potentially a dataset to allow performance measurement of the service (or at least begin informing us of things that we may not have previously known). So, the approach taken was to pursue both.

One of the key enablers in developing this dataset was the newly installed Electronic Medical Records (EMR) software. This came with a reporting platform, but no single report existed which provided all the information we required, so an analytics specification was produced and used to create a custom report to provide this. This was an iterative process with the software supplier's analytics team.

Requirement 1: The production of a register of all doses was required, with an indication of HCD approval status (this would allow us to keep track of what we needed to complete and what had been completed).

Requirement 2: To become up to date and fully compliant. The project identified and systematically uncovered a backlog of HCD applications to complete.

Requirement 3: Process ownership by administrative staff, away from patients, and (as before) approved by a pharmacist (an essential second clinical and quality control check).

Requirement 4: Each patient's eye and drug requires a valid HCD application when the drug is initiated or changed. So, data granularity was required at this level.

In order to be able to measure compliance, we required a numerator (drug used) and denominator (drugs used in compliant Blueteq cases) across relevant initiation and therapy change cohorts. This required a list of who had been given what drug, where and when, and the same data regarding what HCD applications had been completed. We also had to define 'initiation', 'change' or 'neither initiation nor change' statuses in the data (among other things).

Requirement 5: The need to be able to leverage the data to design-out antiquated paper-based systems, inefficient processes, and move the role to administrative-type workstreams.



Example analytics specified item	Description
'injection_date'	Date of the injection in question in row level data
'date_of_first_injection_in_eye_treated'	Logic to identify new therapy initiations in a time period (e.g. January)

Table 2: Example report field data of interest

Example metric	Description
Time in service	Elapsed time between the first and last injection in the eye in question
Count of injections in year 1 of treatment	The number of injections given to the patient in the first 365 days since the first injection.
Average injection interval	The mean time between injections in a given date range.

Table 3: Example metric rationales built off new reporting functionality

The reporting side was developed out of an aspiration to know as much about the service, and patient cohorts as we could. Metrics were built from a set of rationales and logic, from outputs like those shown in Table 3, and our process mapping exercise.

Once this report had been quality assured, for the first time we could produce a dataset covering every dose given. This provided the denominator

(all patients treated); and in effect, what we needed to do to be fully compliant. For the numerator, we used the Blueteq platform reporting functionality to database completed Blueteq request IDs, by patient, by drug, by financial year.

Once we had taken stock of the available datasets, there were several follow-on data-related issues, as part of the data discovery process.



Issue	Solution
There were no linkable drug fields between the two datasets	Create a new common field that appears in both datasets that allows us to link the two. Then use that column to enable one dataset to act as a 'Lookup' against the other.
Developing logic for 'New' and 'Therapy changes'	We coded 'New Therapy' to a report field that provides the 'first injection date', and a 'last change of therapy' to a field provided as elapsed time in days.
Developing a quality assurance process	We compile a database of completed applications by financial year, and crosscheck 10% of our doses against completed applications from before the current financial year. This provides a fair quality control step as part of monthly duties.
Automating repeatable data processes	Some processes have had Excel macros produced for them, but these need to be modified if there is a change in the source data, or a data, reporting or compliance requirement.
Solving data quality issues	As input data is completed by humans, this can be prone to less than 100% completeness, correctness and consistency rates. The datasets can contain errors and artefacts, where variation in dataset presentation or data entry occurs. Therefore, we need to ensure that our data is checked, and certain errors manually corrected.
Backlog completion a significant task	The size of the backlog task can be controlled from the point in time that the Trust decides it needs to be compliant from. The backlog size was therefore dependent on the level of historical compliance that was desired.

Table 4: Problems identified after data discovery

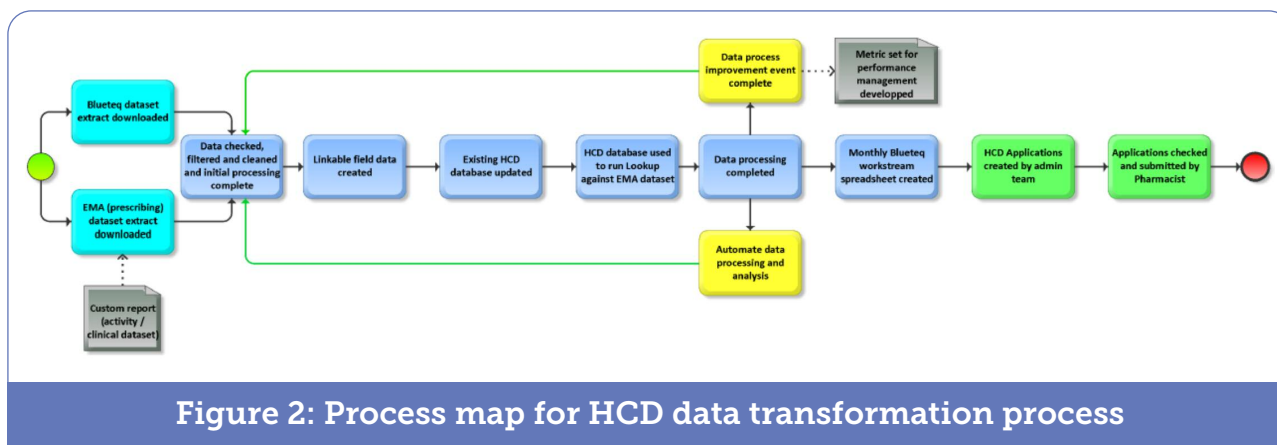
Outcomes and quantitative impact

The optimised process has successfully removed the HCD administrative aspects from the patient pathway, and additionally, away from Ophthalmologist roles. The second outcome was dependent on the first, because this type of administrative process is completed more efficiently as a retrospective batch activity, driven by clinical data products. In addition, we have challenged ourselves to build increasingly granular activity data, which we can use to understand more about the service than we ever have before (and things we may think we will need to know in the future). Our redesigned process now exists as a

set of monthly analytics tasks, where data is downloaded, cleaned, processed and databased.

Figure 2 represents the methodology used to prepare the data. As a data and analysis process, extracts are taken from the respective software, and then checked, cleaned, standardised, filtered and linked. The linked datasets are then compiled into an administrative work package. There are nuances and complexities in this process, due to a lack of software interoperability and data flows. However, good results have been achieved in automating standardised, repeatable steps in this process, through a series of Excel macros.





The HCD applications that then need to be completed are identified and sent to an admin team for completion, which are subsequently approved by a pharmacist. Any queries, wrong or

missing data, or financial challenges may still be queried with the relevant Ophthalmologist, but this again happens away from clinic time.

ID	Value-adding outcomes	Areas of focus	What did we do?
1	Increase value-creating activity	Maximising patient flow, maximise patient-facing clinical time, maximise capacity.	Totally remove HCD administration from clinics, thus releasing previously lost direct clinical time.
2	Eliminate non-value creating activity (wasted effort)	Reduce waits, stop undertaking activities in clinic that do not need to be completed face-to-face.	Switch the task to trained non-clinical admin staff, maintain Pharmacy input, approval and Quality Control.
3	Minimise essential non-value creating activity	Make essential administration as efficient as possible.	Use a data-driven analytical methodology to replace manual, human processing.
4	Minimise the number of process steps as far as possible (simplified processes are more efficient, reliable and safe)	Maintain essential clinical aspects and stop doing other things (where possible) in clinics. Minimise distractions.	Process removed to a parallel admin workstream. Simplification of patient pathway in Outpatient Department. Decision-making steps also reduced.
5	Reduce the time to complete the process steps that comprise the patient pathway	Reduce time to complete processes under investigation (also known as 'Takt Time' in Lean Production theory).	Reduction in process steps, due to removal of those steps from the patient pathway. Data-driven approach to HCD administrative work more efficient.
6	Reduce the wait times between process steps	Reduce unnecessary waiting time.	Reduced clinic wait times as admin process eliminated from the patient-face.

Table 5: A retrospective review of the Value Stream Analysis



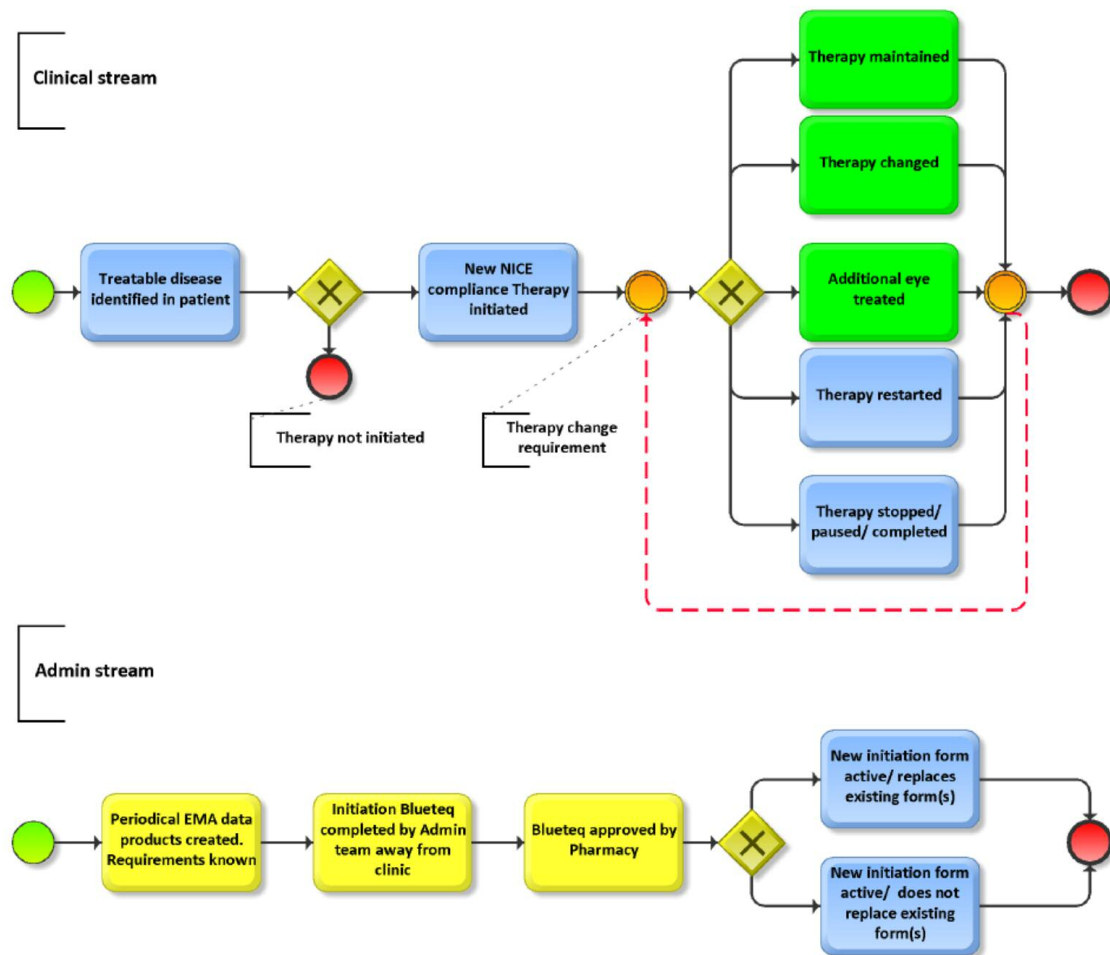


Figure 3: Process map for optimised HCD therapy initiation processes

Figure 3 represents the optimised process, where the administrative work has been removed from the patient pathway. The simplified patient pathway contains two decision points (a reduction from four).

- The decision to treat or not
- The decision to choose one of five therapy outcomes

"A decision to complete a new HCD application, based on commissioner guidelines has been shifted to the administrative process stream. A decision to discontinue or maintain previous applications has been removed entirely."

A corresponding reduction of six process steps to three for each treated patient in the pathway was also achieved, with one less software application required in clinic. A parallel administrative process was created to complete the work away from patients and undertaken by desk-based administrative-type roles.

After review of savings and impacts before and after the pathway optimisation is shown in Table 6. Resources are shown in native currencies (rather than money saved).



Impact statement	Comments	Quantitative impact
We estimate each HCD application takes about 5 minutes to complete using the old process	Upon running the two datasets for the first time, we generated about 6000 incomplete HCD applications over a 10-year period. This is our project backlog.	Our backlog tasking equates to 13.3 weeks, which is around 3 months of consultant time (0.25 FTE for a year).
We identify about 350-700 new HCD applications that require completion each month.	This is the core new admin process.	0.19-0.38 FTE equivalent more Consultant Ophthalmologist time returned to the clinical pathway.
We estimate each HCD application takes about 2 minutes to complete using the new process	Improved efficiency using admin not clinical staff. 0.11-0.22 FTE equivalent admin now required	2.5-fold increase in productivity.
Retrospective process at end of month	Full clinical/ financial accountability in 4-8 weeks of doses given.	N/A
HCD challenges per month of 100-150, reducing to 0-10 after transformation	HCD challenges have to be completed rapidly or can become a financial risk. Therefore disruptive.	90-100% reduction in HCD challenges.
Totally digitalised process	Allows flexible working by admin staff. Paper use stopped	N/A

Table 6: Final measurement and quantitative impact

Summary

After a discussion about exactly what we needed to do, we identified a problem in an area of significant spend, which was to become a large financial risk area. As it can sometimes be harder to work out what to stop doing than what to keep doing, we defined a series of 'issues' and 'requirements' and undertook a Value Stream Analysis to identify how and where to focus. The key was to focus on the 'Value Stream'.

We looked at people, processes and systems, with a view to improving the completeness, consistency and correctness of our HCD application work using the issues and requirements as design necessities or functionality. This iterative process was undertaken over 18-24 months with several rounds of backlog completion and evolving process design revisions and has dramatically improved our compliance and accountability in Ophthalmology.

We focussed on optimising data reporting and automating what we can, as well as responding to new compliance requests and developing a performance measurement toolset. We ended with a process that can adapt to new requirements, and one that has delivered parallel benefits in the form of Business Intelligence (BI) and potentially Real World Data (RWD) generation. We believe this is a beneficial case study in process transformation, data discovery and the application of that data to drive operations, early warnings, and decision making. We have also generated tangible efficiencies that allow clinical resource time to be returned to patient-facing roles.

The work completed in this review raises the question as to how many other similar areas of potential optimisations exist across other NHS clinical and clinical administrative processes and pathways. Future models of data interoperability



could allow for far greater automation of this type of process and save yet more time and resources. However, it is commonplace to have variation in requirements across commissioner-provider arrangements, and so a standardised process for all would greatly simplify the task of any further automation here. It is vital to assess the clinical, information, and process landscape so that the right questions can be asked, and that this type of review begins at the right starting point.

References

- 1 NHS England, News, New NHS measures to improve eye care and cut waiting times, 28th May 2023: <https://www.england.nhs.uk/2023/05/new-nhs-measures-to-improve-eye-care-and-cut-waiting-times/> (accessed 10th July 2026)
- 2 NHS Digital Hospital Episode Statistics (HES) Data: Hospital Outpatient Activity 2024-24, NHS England <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/2024-25> (Last accessed 21/09/26)
- 3 NHS England, Getting It Right First Time (GIRFT), Ophthalmology National Specialty Report, MacEwen C, Davis A, Chang L, December 2019: <https://gettingitrightfirsttime.co.uk/wp-content/uploads/2019/12/OphthalmologyReportGIRFT19P-FINAL.pdf> (accessed 10th September 2026)
- 4 NHS Improvement, An Overview of a Lean, August 2011: <https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2018/06/An-Overview-of-Lean.pdf> (accessed 10th July 2026)
- 5 Radnor Z, Williams S, Lean as a Healthcare Improvement Approach, Cambridge University Press, 9th September 2025: <https://www.cambridge.org/core/elements/lean-as-a-healthcare-improvement-approach/A656E368A6DEFA5D3A2BBADBF18B30C4> (accessed 10th July 2026)
- 6 Kaizen Institute, Value Stream Analysis: The key to leaner operations, (undated): <https://kaizen.com/insights/value-stream-analysis-leaner-operations/#:~:text=Stream%20Analysis%20appeared.,What%20is%20a%20Value%20Stream%20Analysis?,to%20make%20in%20the%20future> (accessed 10th July 2026)
- 7 Alogla A, Revisiting lean healthcare: adopting value stream mapping from manufacturing, Frontiers in Health Services – Health Policy and Management, 4th September 2025: <https://pmc.ncbi.nlm.nih.gov/articles/PMC12443820/> (accessed 10th July 2026)
- 8 Note: All process map illustrations created using 'Aris Express' BPMN (Business Process Model and Notation software (v2.4D) (<https://ariscommunity.com/aris-express>)





Harnessing the Clinical Expertise of Community Pharmacy: Integrating Community Pharmacy into a Unified Primary Care Patient Offer

Re-Engineering Care Pathways, Overhauling the Dispensing Funding Model, and Embedding Independent Prescribing to Deliver Sustainable Neighbourhood Health



Stephen Riley MPharm MSc Health Policy DIC FRCPharm FRMS

Former Northwest Deputy Regional Chief Pharmacist NHS England | Independent Health and Regulatory Policy Consultant | National Adjudicator

About the author and perspective:

Written from the perspective of a former NHS England senior pharmacy leader, health policy lead and GPhC national adjudicator. Stephen Riley is a senior healthcare policy leader, national statutory adjudicator, and system strategist with over 20 years of experience shaping primary care delivery, statutory regulation, and health policy. A former Deputy Regional Chief Pharmacist and National Senior Policy Lead for NHS England. He currently serves as an appointed National Adjudicator (Fitness to Practise) for the General Pharmaceutical Council (GPhC) and acts as an independent executive adviser on health system governance and clinical workforce integration. Stephen holds an MSc in Health Policy (Merit) from Imperial College London and is a Fellow of both the Royal College of Pharmacy and the Royal Society of Medicine.

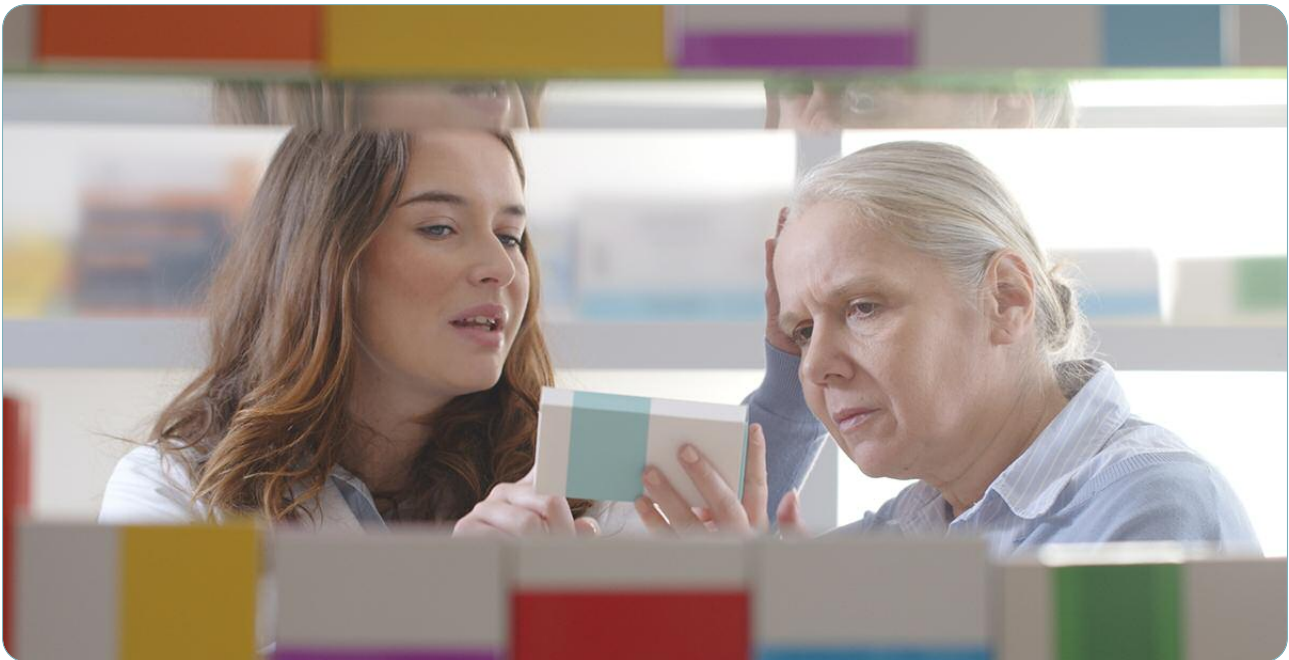
1. Moving from Pharmacy First to Pharmacy Forward: The Golden Thread of Integration

Over the past decade, primary care across England has undergone an unprecedented clinical evolution. In particular, community pharmacy—long mischaracterised as an isolated, transactional dispensing network of shopkeepers—has progressively demonstrated its capability as an essential frontline clinical provider. From the landmark national introduction of the New Medicine

Service (NMS) in 2011 to the rapid scaling of the Discharge Medicines Service (DMS), the Hypertension Case-Finding Service (HCFS), the Pharmacy Contraception Service (PCS), and the groundbreaking Pharmacy First initiative, the sector has repeatedly proven its capacity to deliver high-quality, protocol-driven clinical care at scale. Community pharmacists possess an invaluable skillset and expertise as healthcare generalists, able to swiftly turn their hand to diagnosis and management of low acuity conditions, safe and effective medicines supply, long term condition case finding, population health support, multidisciplinary team working and now independent prescribing.

Yet, reflecting on my experience leading pharmacy integration strategy within NHS England Northwest and across regional health systems, I recognise that our structural transition has a long way to go. As system leaders evaluate the nationwide rollout of Pharmacy First, the fundamental question facing Integrated Care Boards (ICBs) is no longer whether community pharmacy can deliver clinical services—it demonstrably can. The critical strategic challenge today is how England moves from **Pharmacy First** to **Pharmacy Forward**—weaving these expanding clinical capabilities into a consistent, seamless, and dependable primary care offer for every patient. Transitioning our sector from an ad-hoc acute referral service to a permanently embedded, autonomous clinical frontline within primary care.





The golden thread uniting current health policy—from the government's *Fit for the Future: 10 Year Health Plan* for England (July 2025) to the *Model ICB Blueprint*—is that patient care must be continuous, accessible, and integrated. When a citizen experiences a low acuity acute common condition, requires routine blood pressure monitoring, seeks sexual health services, or needs proactive support managing complex long-term conditions, they should be able to access a single, joined-up NHS primary care offer. Community pharmacy represents the most physically accessible clinical asset in the National Health Service across England. Operating at the heart of our local communities, over 10,000 community pharmacies welcome millions of citizens through their doors every week without requiring an appointment. They provide prompt access to highly qualified community pharmacists and registered pharmacy technicians, supported by well-trained support teams.

We stand at a generational inflection point for our profession. The historic shift toward universal Independent Prescribing (IP), where newly qualified pharmacists join the register as prescribers from day one, alongside the national commissioning of IP services within the Community Pharmacy Contractual Framework (CPCF). We are the only profession aside from medics who qualify as IPs from day one. Fundamentally redefining the professional identity of the pharmacist, particularly in community pharmacy. Community pharmacists

are no longer merely managing medicines supply under rigid Patient Group Directions (PGDs); they are autonomous clinical prescribers diagnosing conditions, initiating treatments, and managing therapeutic regimens.

"The strategic imperative of integration

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? Achieving this requires a structural re-engineering of funding, digital pipelines/system interoperability, care pathway design and neighbourhood governance."



2. Frontline Realities and The Burning Platform: Overhauling the Dispensing Model

To achieve Pharmacy Forward, system leaders must confront a stark reality: our expanding clinical ambitions cannot be sustained on an obsolete operational foundation. The legacy dispensing-led funding model, with payment linked to item-based activity fees, is financially and operationally exhausted.

In 2024/25, community pharmacies in England dispensed an astounding 1.26 billion prescription items, driven by a persistent ~4% annual volume growth. This escalating volume, combined with rising overheads and severe operational inflation, has created widening financial instability across the network. The structural flaw lies in the funding mechanism itself: remunerating contractors via item-based activity fees—predominantly the Single Activity Fee (SAF)—rewards raw volume, discourages dispensing efficiency, does not account for service quality and creates an artificial wall between medicines supply and clinical care. Approximately 86% of CPCF income remains tied to traditional dispensing and procurement margin, leaving only ~14% associated with clinical service delivery. This

remuneration structure actively disincentivises the very clinical behaviours the NHS desperately needs: community pharmacists remain in dispensaries managing repeat prescriptions rather than maximising utilisation of their clinical skills in proactive medicines review, chronic disease management, and autonomous prescribing.

The real-world consequences of this economic fragility are starkly documented in the House of Commons Library Research Briefing *Community Pharmacy in England* (CBP-9854). Between February 2016 and February 2026, England experienced a net loss of 1,083 community pharmacies—a 9% contraction of the national network (falling from 11,609 to 10,526 premises). Compounded by an accompanying reduction in operating hours. Large corporate multiples and independent owners alike have been forced into widespread branch rationalisation due to unsustainable operating margins.

The independent Economic Analysis conducted by Frontier Economics and IQVIA for NHS England exposed the true scale of this sector crisis. Evaluating the 2023/24 financial year, the review established that total NHS funding (£2.8 billion) was exceeded by pharmacy-level operating costs by £0.7 billion, while the full economic deficit reached £2.3 billion. The

Operating Dimension	Legacy Dispensing Model	Integrated Neighbourhood
Funding Architecture	Volume-driven Single Activity Fee (SAF); ~86% dispensing / ~14% clinical split; margin volatility.	Bundled capitated and outcomes-based remuneration; protected clinical consultation capacity.
Primary Clinical Function	High-volume repeat dispensing; PGD-bound minor ailment supply.	Autonomous Independent Prescribing; proactive long-term condition management; CVD screening.
Patient Access Mechanics	Referral-dependent 'push' signposting from GP practices; variable uptake.	Patient-initiated walk-in 'pull' access; direct self-referral via NHS App; automated triage.
Digital Infrastructure	Siloed pharmacy IT; manual PDF notifications; lack of GP record visibility.	Bidirectional read/write access to Single Patient Record via GP Connect and EPS.

Table 1: Comparative Operating Framework – Legacy Dispensing vs. Integrated Neighbourhood Model





report revealed that between 45.5% and 96.6% of pharmacies were operating with funding below basic operational costs. In May 2024, the Health and Social Care Select Committee concluded unambiguously that the CPCF is “not fit for purpose”, “overly complex”, and requires root-and-branch overhaul.

Financial fragility directly compromises operational continuity. Freedom of Information data across all 42 ICBs revealed that in 2023 alone, there were 13,863 temporary pharmacy closures, resulting in over 46,800 lost operational hours (averaging 3 hours and 40 minutes per incident), driven primarily by locum shortages and acute wage inflation. Simultaneously, workforce challenges have exacerbated sector pressures. While registered pharmacist numbers reached 56,845 in early 2026, 60% of pharmacy teams report staffing shortages. A major driver has been the rapid expansion of the Additional Roles Reimbursement Scheme (ARRS), which recruited over 7,400 full-time equivalent pharmacists into general practice networks by late 2025 without a coordinated primary care workforce strategy—drawing experienced clinicians away from community pharmacy. This workforce drain occurred alongside massive cost shocks from the Autumn 2024 Budget, imposing an estimated £115m–£152m annual National Living Wage increase and a £50m Employer National Insurance burden on pharmacy contractors from April 2025.

“The case for change system leaders

The case for change is absolute. The legacy dispensing model is financially and operationally exhausted. ICBs and national policy makers must replace volume-based item fees with clinically focused service bundled, outcomes-focused commissioning that releases pharmacist capacity for clinical care, prescribing, and neighbourhood integration.”



3. Unlocking System Value: The Proven Impact of Integrating Community Pharmacy

Establishing robust, integrated pharmacy programmes yields profound benefits across the entire healthcare system, fulfilling the NHS Quadruple Aim: improving population health, enhancing patient experience, reducing healthcare costs, and supporting workforce sustainability.

Community pharmacies represent a significant health equity asset in primary care. Located within walking distance for the vast majority of the population—and concentrated in areas of high socioeconomic deprivation—pharmacies help narrow the health inequalities gap by providing prompt, walk-in style clinical care without appointment barriers.

National operational data underscores this reach. Between April 2025 and January 2026, community pharmacies in England delivered over 2.75 million Pharmacy First clinical pathway consultations, nearly 1 million contraception consultations, and 3 million hypertension case-finding checks, alongside dispensing approximately 1 billion prescription items. Cumulative Pharmacy First pathway claims exceeded 4.5 million consultations across 10,900 participating pharmacies. Patient satisfaction rates for these integrated clinical services consistently exceed 98%, with public evaluation praising the speed, convenience, and professional rigor of pharmacy consultations.

Beyond acute care, integrated pharmacy services drive immense clinical value in managing chronic disease and optimising medicines spend. The New Medicine Service (NMS), proven by NICE-backed evidence to significantly increase long-term medication adherence, reduce adverse drug reactions, and lower health system costs. Similarly, the Discharge Medicines Service (DMS) bridges the fragile transition between hospital discharge and community care, ensuring rapid post-discharge reconciliation, eliminating dangerous prescription discrepancies and significantly reducing 30-day emergency hospital readmission rates.

The practical capacity value of cross-sector primary care integration is powerfully demonstrated by a recent structured partnership between general practice and community pharmacy in Greater Manchester.

Over the six-month evaluation period, referring eligible patients to community Pharmacy Independent Prescribing (IP) Pathfinder clinics and Pharmacy First services released a total of 177.25 hours of GP practice clinician time (comprising 48.5 hours released via IP pathfinder services and 128.75 hours via Pharmacy First). By transferring these consultations to community pharmacy prescribers and clinical teams, general practice capacity was directly repurposed. This could deliver any of the following services:

- **709 Additional GP consultations** for complex multi-morbid patients
- **531 Specialist GP consultations** for complex chronic disease management
- **2,127 Complex triage assessments** managed by practice clinicians
- **354 Specialist women's health procedures** performed by GPs
- **354 Minor surgical procedures** delivered within general practice
- **709 Joint injections** administered for musculoskeletal care

Simultaneously, integrating routine contraception requests and Ambulatory Blood Pressure Monitoring (ABPM) into community pharmacy released 104.25 hours of general practice nursing time (48.25 hours from contraception supply and 56 hours from ABPM monitoring). This was repurposed as nursing capacity. This could deliver any of the following services:

- **417 cervical cancer screening smear tests**
- **625 blood test appointments**
- **313 diagnostic ECGs**
- **625 diabetic foot checks**
- **417 structured asthma or COPD reviews**
- **625 therapeutic injections** (including Zoladex, Inclisiran, B12, and vaccinations).

Beyond releasing primary care capacity, embedded community pharmacy prescribers play a vital role in clinical safety, early diagnosis, and life-saving interventions. As highlighted in the North West Pharmacy Integration Report (January 2026), the clinical value of community pharmacy independent prescribing pathfinders extends far beyond minor ailment resolution.



"Clinical Case Study: Life-Saving Cancer Referral in Community Pharmacy

A patient presented at a community pharmacy IP Pathfinder clinic seeking advice for a persistent, non-healing ear lesion. Utilizing advanced physical assessment skills and clinical diagnostic judgment, the community pharmacist prescriber recognised red-flag indicators suggestive of cutaneous malignancy and immediately initiated an urgent 2-Week Wait (2WW) referral to secondary care head and neck surgical oncology.

Subsequent specialist biopsy confirmed a diagnosis of Squamous Cell Carcinoma (SCC). Thanks to the pharmacist's prompt clinical assessment and direct referral, the patient underwent successful surgical excision prior to metastatic spread. The patient later returned to the pharmacy to express personal gratitude, noting that the community pharmacist's clinical vigilance and rapid escalation had effectively saved their life."

Illustrating a critical strategic principle: community pharmacists operating as independent prescribers within integrated clinical pathways act as highly trained diagnostic eyes on the high street, detecting red-flag presentations early, accelerating cancer referral pathways, and safeguarding patient health.

The North West region provides a compelling blueprint for regional integration delivery, stemming from a regional leadership approach, establishing a collaborative delivery unit between regional NHSE and ICB pharmacy leadership and matrix working model. Across the regional systems community pharmacy services such as Community Pharmacy Hypertension Case-Finding and Pharmacy First are proactively integrated into care pathways and collaborative relationships between GP Practice and community pharmacy are supported.

Across 2025/26 (data to October 2025), North West community pharmacies achieved unprecedented scale across core clinical pathways:

- **Pharmacy First Delivery: Over 494,000 patients supported** across clinical pathways, minor illness, and urgent medicines supply, providing vital local urgent care capacity.
- **Community Pharmacy Hypertension Case-Finding: Over 361,000 consultations delivered.** Crucially, the service identified **over 10,000 previously undiagnosed hypertensive patients** (to August 2025)—potentially preventing up to **10,000 major cardiovascular events** (strokes and myocardial infarctions) across the region.
- **Pharmacy Contraception Service: Over 76,000 consultations delivered.** Following the inclusion of emergency contraception from October 2025, 370 women received immediate access in the first month alone.
- **Independent Prescribing Pathfinder: Supported over 4,400 patients** across ICBs (Jan-Sept 2025), testing minor illness, chronic disease management, and lipid optimisation prescribing models, shaping the forthcoming national commissioning models.



“Measureable system value of community Pharmacy Integration

The frontline evidence is decisive. Cross-sector pharmacy integration repurposes hundreds of GP and nurse hours toward high-complexity care, detects early-stage cancers through direct red-flag referrals, and prevents thousands of cardiovascular events across local populations.”

4. Sector Ambitions vs. Commercial Realities: Navigating the 2026/27 CPCF Settlement and IP Rollout

To construct a sustainable future, leaders must candidly examine the development of the community pharmacy sector, balancing high national policy ambitions against frontline commercial realities. The stark realities of sector funding, workforce and capacity challenges are further compounded by the financially constrained NHS commissioning infrastructure, amid the biggest wholesale overhaul since the introduction of the Health and Social Care Act in 2012.

The 2026/27 CPCF agreement represents a crucial step toward sector stabilisation. The agreement establishes a total funding envelope of £3.636 billion for 2026/27—a 10.3% uplift (£340 million) over 2025/26, building upon the 19.7% uplift delivered across 2024–2026.

Key structural elements of the 2026/27 settlement include:

- **Prioritising Core Supply:** The Single Activity Fee (SAF) increases from £1.46 to £1.52 (a 4.1% rise backdated to May 2026), injecting cash-flow support directly into core dispensing.

- **Margin Expansion and Debt Relief:** Allowed retained medicine margin increases by £200 million to £1.1 billion, while up to £239 million of historic net over-delivery debt is written off.
- **Budget Consolidation:** Merging the dedicated £215 million Primary Care Access Recovery Plan / Pharmacy First budget directly into the core CPCF sum guarantees the clinical funding envelope and eliminates underspend clawback risks.
- **Regulatory Flexibilities:** Permitting pharmacies to close for up to 4 hours per month for protected staff training provides essential capacity for clinical upskilling.

The most profound milestone in modern pharmacy history is the national introduction of independent prescribing services within the CPCF from autumn 2026. Community pharmacist prescribers will prescribe directly within Pharmacy First and contraception pathways, while introducing up to five new prescribing-only clinical pathways covering conditions such as bacterial conjunctivitis, allergic conjunctivitis, oral thrush, mild acne, and episodic migraine. Supported by a £500 setup payment, a £525 monthly infrastructure payment, and a £17 consultation fee.

Despite the 2026/27 funding uplift, system leaders must acknowledge the very real funding concerns voiced by community pharmacy representative bodies:

- **Community Pharmacy England (CPE)** accepted the settlement with serious caveats, warning that while the 10.3% uplift is welcome, the provided IP funding (£525/month infrastructure and £17 consultation fee) risks underestimating the true costs of clinical governance, IT integration, and enhanced professional liability. CPE stressed that pharmacy owners must individually evaluate the commercial viability of IP services.
- **The National Pharmacy Association (NPA)** and Independent Pharmacies Association (IPA) emphasised that years of real-terms funding erosion, combined with Autumn Budget 2024 tax and wage increases (£165m–£202m total sector cost), mean the settlement falls short of full economic



recovery. They caution that expanded clinical responsibilities must not be funded by squeezing baseline dispensing viability.

“Commercial reality check

National policy ambitions must align with frontline economic realities. The 2026/27 settlement provides vital stabilisation, but commissioners cannot expect pharmacy owners to absorb independent prescribing liabilities without local operational support, protected learning time, and equitable commissioning models.”

5. Operationalising Neighbourhood Health: Strategic Mandates for ICBs and INTs

Translating policy intent into frontline reality requires embedding community pharmacy into the core operating architecture of Integrated Care Boards and Integrated Neighbourhood Teams.

Under the *Model Integrated Care Board Blueprint*, ICBs are transitioning into lean, intelligent strategic commissioners focused on population health management, reducing inequalities, and commissioning end-to-end community care pathways. With the complete statutory delegation of primary pharmaceutical commissioning, ICBs possess the full authority to design unified primary care offers. ICBs must stop treating community pharmacy as an insulated contractor silo. Strategic commissioning plans must integrate pharmacy clinical capabilities into every chronic disease pathway, cardiovascular prevention strategy, and urgent care access model.

The national rollout of Integrated Neighbourhood Teams (INTs) and Neighbourhood Health Centres (NHCs) under the 10 Year Health Plan provides

the natural operational vehicle for integration. Community pharmacies are the logical physical and clinical anchors of neighbourhood health. Pharmacies must be formally integrated into INT governance structures. Rather than operating as external suppliers, funded Neighbourhood Community Pharmacy Leads must sit on multidisciplinary team boards alongside general practitioners, community nurses, and social care leads.

Crucially, as highlighted in my MSc dissertation research on community pharmacy service integration, embedding community pharmacy requires shifting primary care clinical leader mindsets so that community pharmacy is recognised as a collaborative clinical ally rather than a commercial competitor, recognising the patient care and system value delivered by the sector. Historic friction around shared services, such as vaccination delivery, demonstrates challenges when community pharmacy is viewed as a commercial threat. Substantively funding Community Pharmacy Clinical Leads gives the sector a strategic seat at Integrated Neighbourhood Team boards to foster collaborative trust and align clinical priorities.

Furthermore, as highlighted in system transformation analyses, we must apply the proven disciplines of the NHS Elective Care Recovery Programme to primary care integration:

- **Protect Dedicated Capacity:** Just as surgical hubs protected elective capacity, ICBs must move from opportunistic community pharmacy utilisation to commissioned, ring-fenced consultation capacity in community pharmacies.
- **Standardise Pathways Across Systems:** Eliminate local postcode variation by deploying uniform national clinical protocols, clear referral criteria and integrated local care pathways.
- **Integrate Digital Triage and AI Platforms:** Embed community pharmacy options into general practice AI total triage tools, NHS 111, and the NHS App, making pharmacy the default first-contact pathway for suitable conditions.





Strategic Roadmap for Leaders:

For ICB Chief Executives, CMOs, Chief Pharmacists, and Primary Care Directors:

- **Substantively Fund Neighbourhood Leadership:** Formally appoint and fund Community Pharmacy Clinical Leads (CPCLs) and Neighbourhood Pharmacy Leads within ICB executive structures and INT leadership boards.
- **Enforce Single-Patient-Record Interoperability:** Issue an executive directive requiring primary care IT suppliers to deliver full bidirectional read/write EHR access via GP Connect and EPS by Q4 2026/27.
- **Pilot Redesigned Dispensing Commissioning:** Test regional pilot models that bundle dispensing, clinically focused service and medicines optimisation payments, shifting away from item-based SAF fees toward capitated, outcomes-based remuneration.

For Medical Directors, PCN Clinical Directors, and GP Leaders:

- **Institute Co-Designed Default Triage Pathways:** Restructure practice management and digital triage platforms so minor ailments, routine hypertension checks, contraception renewals, and NMS adherence reviews automatically route to community pharmacy.

- **Build Shared Clinical Quality Boards:** Establish joint GP-pharmacy Clinical Quality Boards to review cross-sector safety incidents, audit prescribing safety, and oversee independent prescribing rollout.
- **Align ARRS and Community Pharmacy Teams:** Integrate PCN-funded ARRS clinical pharmacists with high-street community pharmacy prescribers, establishing shared clinical supervision, joint case conferences, and unified chronic disease management pathways.

For Lead Pharmacists, LPC Leaders, and Pharmacy Owners:

- **Adopt the Professional Assurance Framework:** Implement NHS England's Professional Assurance Framework and Commissioning Guidance for community pharmacy prescribing to ensure consistent clinical governance.
- **Establish Local Clinical Supervision Hubs:** Create ICB-supported peer discussion hubs and clinical supervision networks to mentor practising pharmacist prescribers.
- **Utilise Protected Learning Capacity:** Schedule up to four hours per month of protected staff training time using 2026/27 CPCF flexibilities to complete mandatory PQS audits and advanced therapeutics training.



KEY TAKEAWAYS

- **Strategic Integration as Primary Care Policy:** Embedding community pharmacy as an equal clinical partner within Integrated Neighbourhood Teams (INTs) and Neighbourhood Health Centres is essential to delivering the government's 10 Year Health Plan and executing the strategic shift from acute hospitals into local communities.
- **Definitive Reform of the Dispensing Funding Model:** With independent economic analysis establishing a £0.7bn to £2.3bn sector deficit alongside a 9% network contraction, system leaders must look beyond the £3.636bn 2026/27 CPCF settlement and transition toward bundled, capitated, and outcomes-based commissioning that decouples professional activity from raw dispensing volume.
- **Capitalising on Universal Independent Prescribing (IP):** The national rollout of IP across five new prescribing pathways—combined with day-one prescriber graduates entering the workforce—fundamentally elevates the clinical scope of the sector. Realising this vision requires ICBs to invest in local clinical supervision, diagnostic access, and shared liability frameworks.
- **Mandating Interoperability and Collaborative Governance:** Achieving seamless patient journeys demands full bidirectional read/write access to the Single Patient Record via GP Connect and EPS, supported by funded Community Pharmacy Clinical Leads (CPCLs) and joint GP-pharmacy Clinical Quality Boards to repurpose clinician hours and drive population health outcomes.
- **Reframing Perceptions and Strengthening Clinical Leadership:** Highlighted in my MSc dissertation research on community pharmacy service integration, system leaders must actively reframe community pharmacy as a collaborative ally rather than a commercial threat. Embedding funded Community Pharmacy Clinical Leads directly within Integrated Neighbourhood Team boards is vital to building interprofessional trust, overcoming historical service friction, and co-designing primary care pathways.

6. Conclusion: Achieving Permanence for Integrated Primary Care

The restructuring of NHS primary care is no longer a theoretical debate; it is an active operational imperative. As health systems confront rising demographic demand, severe fiscal constraints, and primary care access pressures, community pharmacy provides an unmatched, highly skilled clinical asset capable of transforming patient care.

By framing integration around the golden thread of patient value, overhauling the obsolete dispensing funding model, embracing independent prescribing, and embedding pharmacy directly within Integrated Neighbourhood Teams, we can build a joined-up primary care system where every citizen receives prompt, expert, and compassionate care in their local community. The policy framework is set; the clinical capability is proven;

the strategic horizon is clear. Executive leaders must now execute this roadmap to deliver an integrated NHS fit for the future.

Formal Declarations and Conflicts of Interest

The author declares no direct commercial conflicts of interest or financial relationships with proprietary pharmaceutical manufacturers or commercial software vendors. All views expressed are authored strictly in an independent capacity and do not represent the official positions of the General Pharmaceutical Council, NHS England, or affiliated statutory bodies.





Pharmacy Teams as Gatekeepers for Suicide Prevention: Implications for Pharmacy Education and Workforce Development

Dr Lisa Edwards

Assistant Professor/Postgraduate Lead, Faculty of Health and Social Care, University of Bradford.

Email: L.Edwards@bradford.ac.uk

Abstract

Background: Community pharmacy is an accessible setting in which patients at risk of self-harm or suicide may present repeatedly, sometimes through medication-related crises, requests for potentially lethal quantities, or informal help-seeking conversations. Yet the profession has historically lacked consistent role definition, training, and referral infrastructure for suicide prevention.

Objective: To synthesise the case for pharmacy teams as suicide prevention gatekeepers and examine the implications for pharmacy education and workforce development within the UK context.

Sources and content: This paper presents a narrative synthesis of pharmacy-specific suicide prevention evidence and its implications for UK pharmacy education and practice. It is not an original systematic or scoping review. Evidence is drawn from published scoping reviews alongside primary qualitative, survey, educational and intervention studies, with particular attention to the transferability of international findings to the UK context. Evidence from scoping reviews, qualitative studies, surveys, curriculum evaluations, and one recent cluster randomised trial indicates that pharmacy teams frequently encounter suicide warning signs in practice but often do so without formal preparation. Community pharmacists and other pharmacy staff describe providing emotional support, triage, signposting, and medication-related interventions while facing barriers including time pressure, limited privacy, uncertainty about referral pathways, and lack of organisational guidance. Pharmacy-specific gatekeeper training programmes improve knowledge, preparedness, and self-efficacy, and simulation-based evidence suggests they can meaningfully improve

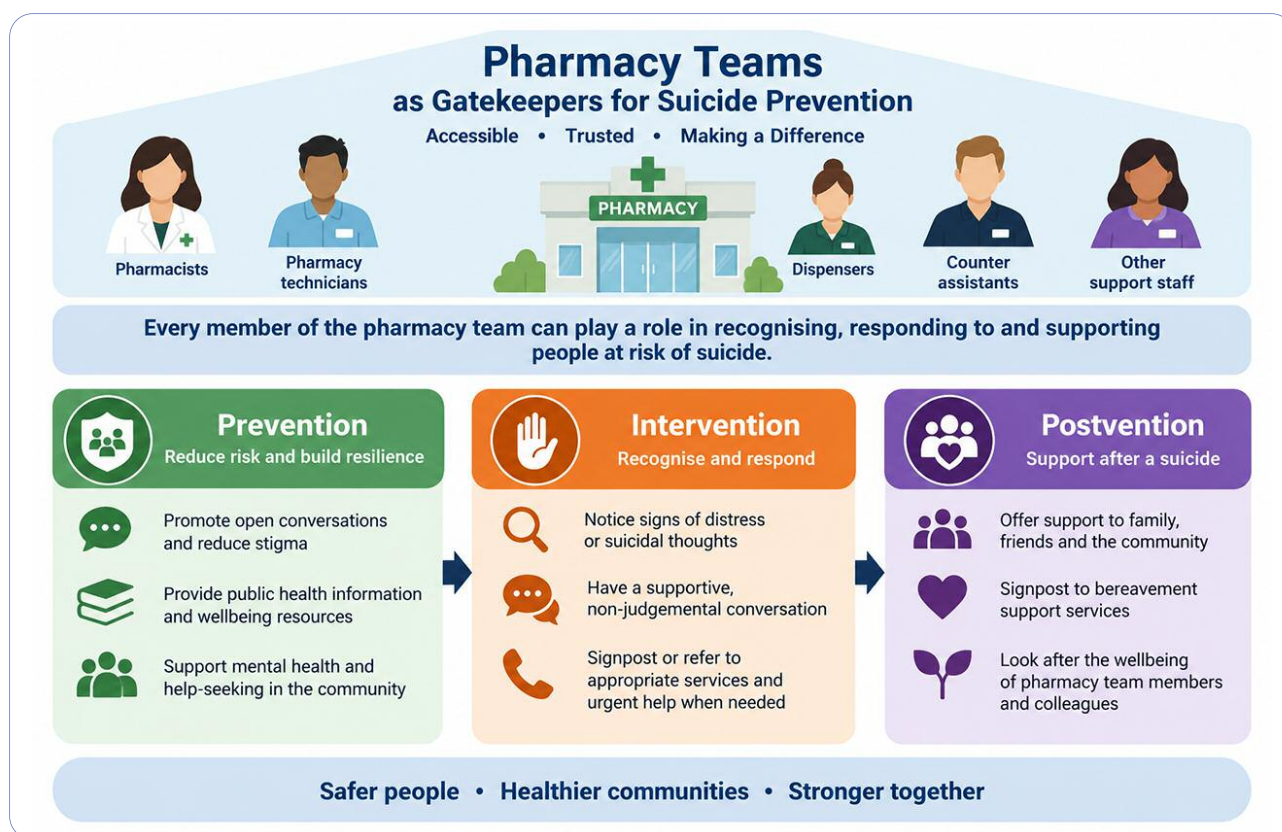
behaviours such as directly asking about suicide and making crisis-line referrals. Student pharmacist interventions similarly show gains in confidence, comfort, and communication readiness, although the educational literature remains limited.

Summary: The available literature supports a team-based, pharmacy-specific conception of suicide prevention gatekeeping centred on recognising warning signs, asking directly, validating distress, supporting referral, documenting, and following up within scope. Responsibilities should be differentiated according to role, with pharmacists retaining distinctive medication-safety responsibilities. However, training alone is unlikely to be sufficient. Sustainable implementation depends on system supports including workflows, referral relationships, governance, and post-incident support for staff wellbeing.

Initial pharmacist education provides an important opportunity to begin developing suicide prevention capability in future pharmacists, alongside role-appropriate training and continuing professional development across the wider pharmacy workforce. A competency-based spiral curriculum, aligned with existing professional standards and assessed through observed performance, could embed this capability without requiring a disconnected standalone module. Future research should move beyond knowledge outcomes to implementation, patient-centred outcomes, equity, and the real-world effectiveness of pharmacy-based interventions.

Keywords: suicide prevention; community pharmacy; pharmacy teams; gatekeeping; pharmacy education; workforce development; medication safety





Introduction

Effective suicide prevention depends on multi-sector, multi-agency collaborative working. There are potentially multiple points of contact with those at risk of suicide across several systems, including settings that are visited frequently, are informal and trusted. Community pharmacy is one such setting. Patients may encounter pharmacy teams more often than they see other clinicians in the healthcare system, and those interactions can occur during moments of medication crisis, emotional distress, or escalating risk of self-harm. This makes contact with pharmacy staff distinct from many other frontline environments. Within these teams, pharmacists are not only accessible communicators but also stewards of medication supply. The ability to notice medicine-seeking patterns, identify high-risk combinations, restrict access to potentially lethal quantities, and connect patients with urgent help places community pharmacy in an important position within the suicide prevention space.

The role of the pharmacy in the community has developed faster than the structures that support it. Existing literature consistently portrays pharmacy teams as encountering patients with warning signs of suicide while lacking clear role definitions, local

pathways, or routine training (Murphy et al., 2017; Carpenter et al., 2020; Gorton et al., 2019; O'Driscoll et al., 2023). In a large survey of community pharmacy staff in North Carolina, 22.4% knew a patient who had died by suicide and 21.6% had received a request for a lethal dose of medication, yet only 8.8% reported having suicide prevention training or resources and 89.6% wanted such training (Carpenter et al., 2020). Although these US data cannot be assumed to represent the prevalence of such encounters in UK practice, they illustrate the types of suicide-related situations that pharmacy teams may encounter and reinforce the need for context-specific UK evidence.

Geographical context and transferability of the evidence

The primary practice and educational context considered in this paper is the United Kingdom, although the available pharmacy-specific suicide prevention literature is international. The evidence is geographically uneven and is concentrated particularly in North America and Australia. In their scoping review of pharmacists' experiences, perceptions and attitudes towards suicide prevention, Kamal and Jacob (2023) identified five studies from the United States, five from Australia



and/or Canada, one from the United Kingdom, one undertaken across several European countries and one from Japan. Similarly, the training literature reviewed by Stover et al. (2023) was dominated by programmes undertaken in the United States and Australia. UK-specific empirical evidence is consequently much less developed.

The international literature nevertheless provides useful evidence about the types of suicide-related encounters experienced by pharmacy teams, barriers to intervention and the potential effects of gatekeeper education. Transferability should not, however, be assumed. Pharmacy education, professional roles, funding arrangements, medication-supply systems, referral pathways and access to crisis services differ between countries. For example, US PharmD programmes and the US crisis-response infrastructure are not directly equivalent to the UK MPharm programme or NHS and third-sector pathways. Findings from US studies are therefore used here to inform the plausibility, content and educational principles of pharmacy-based suicide prevention rather than to estimate the prevalence of suicide-related encounters within UK pharmacy practice.

There is nevertheless evidence of common underlying issues across countries. Studies from England, Ireland, North America and Australia repeatedly identify accessibility and continuity of contact as potential facilitators, while insufficient training, uncertainty about professional roles, limited privacy, time pressure and unclear referral arrangements recur as barriers. The qualitative study by Gorton et al. (2019) is particularly important to the UK context because it involved the wider community pharmacy team in England and demonstrated that staff were already supporting people contemplating suicide or self-harm despite none having received formal suicide prevention training.

Throughout this paper, the term 'pharmacy team' is used to recognise the range of staff who may interact with members of the public within pharmacy settings, including pharmacists, pharmacy technicians, dispensers, pharmacy counter assistants, and other support staff. Although roles, responsibilities and scope of practice differ, any member of the pharmacy team may be the first person to encounter an

individual experiencing psychological distress or suicidal thoughts. Suicide prevention gatekeeping within pharmacy should therefore be considered a team-based capability, with education and training tailored appropriately to role and level of responsibility.

This paper argues that pharmacy teams should be conceptualised as potential frontline gatekeepers in suicide prevention, with differentiated responsibilities according to role and scope of practice. Pharmacists have an additional medication-safety role arising from their responsibilities for medicines supply and optimisation. Drawing on the evidence synthesis, the paper develops three linked propositions. First, pharmacy already functions as a point of informal gatekeeping, particularly in community settings. Second, expanded clinical and public health roles increase the opportunity for pharmacy-based suicide prevention, but this must be matched with appropriate education, referral pathways, and systems support. Third, suicide prevention capability should be developed through initial pharmacist education and reinforced through role-appropriate training and continuing professional development across the wider pharmacy workforce.

"This paper is a narrative evidence synthesis rather than an original systematic or scoping review. Published scoping reviews are used to characterise the existing evidence base and are supplemented by primary qualitative, survey, educational and intervention studies relevant to pharmacy suicide prevention and to consideration of transferability to the UK context. No PRISMA-style study-selection process is claimed."





Understanding Gatekeeping in Pharmacy

In public health and mental health education, gatekeeping commonly refers to the ability of nonspecialist individuals to recognise warning signs, initiate supportive conversation, and facilitate referral to more specialised care. For pharmacy, that concept requires some further explanation and refinement. Gatekeeping in pharmacy should not be defined as performing comprehensive psychiatric assessment or assuming specialist responsibility for risk stratification. Rather, a pharmacy-specific gatekeeping model can be understood as a scope-appropriate sequence of actions: recognising warning signs; asking directly and sensitively about suicide when indicated; validating distress; taking immediate protective steps that are feasible within the individual team member's role; facilitating referral or emergency escalation; documenting or communicating concerns when appropriate; and following up within role boundaries.

This conceptual model matters because it distinguishes gatekeeping from formal diagnosis or

specialist mental health assessment. The distinction reduces the risk that pharmacy staff interpret suicide prevention as outside their scope simply because they are not mental health professionals. It also clarifies that gatekeeping includes pharmacy-specific interventions related to medicines, some of which sit particularly within the pharmacist's responsibilities. In practice, this may involve limiting quantities of medicines, declining unsafe requests, promoting safe storage, using compliance packaging, identifying risky stockpiling patterns, or adapting medication-related services in ways that reduce access to means while preserving therapeutic support and patient rapport. Recent pre-implementation work on lethal means management in community pharmacies suggests that these functions are not peripheral to suicide prevention; they may be among the most distinctive contributions pharmacy can make (Lavigne et al., 2025).

A pharmacy model of gatekeeping must also be explicitly team-based. Qualitative studies show that technicians, dispensers, counter staff, and other team members are often involved in first contact, telephone encounters, and the practical



management of patient privacy (Gorton et al., 2019; O'Driscoll et al., 2023). The educational implication is that future pharmacists require not only interpersonal competence but also organisational and leadership capability. They need to be able to support scripts, escalation pathways, role clarity, and a team culture that enables the whole pharmacy to recognise concern, respond within scope and escalate safely.

Pharmacy Is a Frontline Suicide Prevention Setting

The strongest argument for pharmacy as a frontline setting is the consistency with which the academic literature describes exposure to suicide. Across studies from the United States, the United Kingdom, Ireland, Australia, and Canada, community pharmacy staff report regular interactions with people experiencing suicidality, self-harm risk, severe distress, or medication-related crisis. Carpenter et al. (2020) found that interactions occurred both face to face and by telephone, indicating that opportunities for recognition and intervention extend beyond formal consultations and interactions. Gorton et al. (2019) reported that community pharmacy team members in England frequently described supporting people contemplating self-harm or suicide, but none of the participants had received suicide prevention training. O'Driscoll et al. (2023) similarly found that pharmacists and pharmacy staff in Ireland commonly encountered at-risk patients yet described uncertainty about how to respond, particularly in the absence of guidelines and appropriate training.

This frontline role is reinforced by the significance of medication access. Murphy et al. (2017) identified the "gatekeeping of medication supply" as a dominant theme in the literature and highlighted the underdeveloped nature of evidence regarding outcomes. The pharmacist's potential contribution therefore is not limited to referral but also lies in noticing and responding to medication-related risk in ways other services may not see. That may include repeated early refill requests, requests for toxic quantities, unusual combinations of sedating or high-risk medicines, or concerns emerging during counselling for newly prescribed psychotropic medication. Because intentional overdose remains a common method

of someone taking their own life, pharmacy consultations may offer a distinctive opportunity for means restriction and early intervention.

"Barriers to this are well documented in the academic literature. Time pressure, lack of privacy, stigma, fear of saying the wrong thing, uncertainty about referral options, and ambiguity about professional boundaries recur across settings (Murphy et al., 2017; Gorton et al., 2019; Kamal and Jacob, 2023; O'Driscoll et al., 2023). These barriers are not insignificant and implementation of suicide prevention in pharmacies will shape whether training translates into action. A pharmacist may know how to ask about suicide yet still avoid the conversation in a crowded pharmacy with no private space and no clear next step after disclosure. For this reason, the gatekeeper concept must remain a consideration for the pharmacy environment and not only individual confidence."

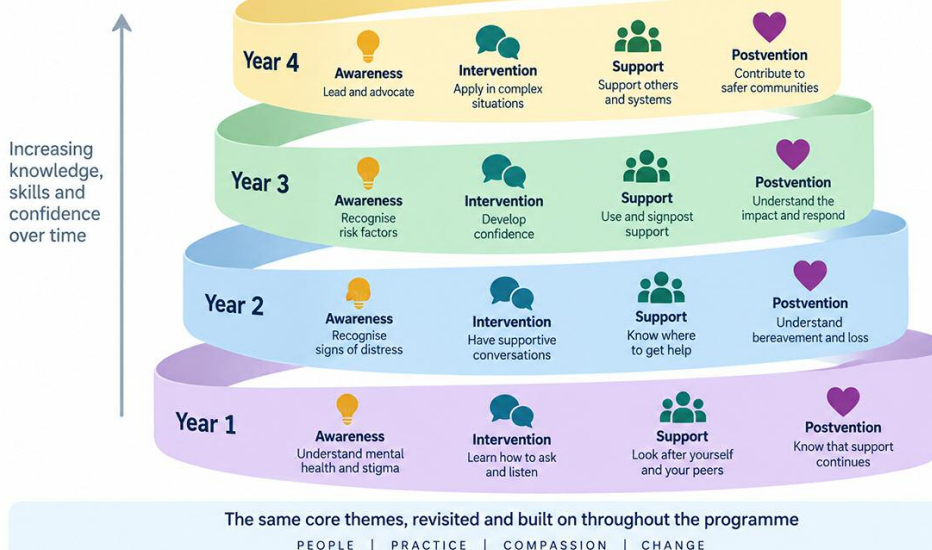
An under-recognised aspect of frontline exposure is postvention and the wellbeing of the workforce. In a cross-sectional survey of community pharmacists in Australia and Canada, 84% reported encountering patients at risk of suicide, 28% had lost patients to suicide, and 10% reported negative personal impact from suicide care experiences (El-Den et al., 2022). Among those negatively affected,



Suicide Prevention in Undergraduate Education

A spiral curriculum: revisit, deepen, apply

*Safer
people
Brighter
futures* ♥



only 12% accessed professional support, commonly because they were unsure where to seek help. This finding is important as it underlines the fact that suicide prevention work is already happening in pharmacies and suggests that responsible gatekeeping includes preparing pharmacy staff for the emotional burden and aftermath of suicide-related experiences.

Expanded Pharmacy Roles and Their Implications

The case for pharmacy teams as potential suicide prevention gatekeepers is becoming stronger as pharmacy practice expands in the UK. In England, this trajectory is visible in the introduction of Pharmacy First and the broader shift toward positioning community pharmacy as a more integrated clinical access point within primary care (NHS England, 2024). Contemporary pharmacy teams increasingly contribute to public health, medicines optimisation, screening, and clinical care, while pharmacists also take on expanded clinical and prescribing responsibilities. These developments create more opportunities to detect distress, discuss risk, and build continuity with patients. They also create more occasions when safety concerns overlap with mental health, including medicine adherence, toxicity risk, substance use or acute deterioration.

Evidence from service development and pre-implementation work illustrates this. O'Reilly et al. (2015) showed that community pharmacists could deliver depression screening and risk assessment services after training, with many of those screened subsequently referred to general practitioners or psychologists. Although depression screening is not equivalent to suicide prevention, it demonstrates that pharmacists can host structured conversations about mental health, risk, and referral when appropriate workflow and training are in place. More recently, Lavigne et al. (2025) explored pharmacy-based lethal means management innovations across six US states, including compliance packaging, adaptations to medication therapy management, suicide risk labelling, gatekeeper training, crisis-line referral, naloxone distribution, and even changes to over-the-counter package size. Their analysis demonstrates not only promising innovations but also the practical conditions needed to sustain them, particularly reimbursement, informatics, and operational considerations.

These findings point to a crucial issue: expanded pharmacy roles do not automatically produce effective suicide prevention. They enhance the opportunity, but implementation will depend on governance. Pharmacies need referral pathways or directories, documentation, escalation protocols, supervisory support, and relationships with local



mental health, crisis, and third-sector services. They also need clarity about what different members of the pharmacy team should and should not do, particularly when balancing patient autonomy, confidentiality, therapeutic alliance, and immediate safety. UK policy and quality standards similarly stress multi-agency working, reducing access to methods of suicide, and coordinated support for people affected by suicide (Department of Health and Social Care, 2023; National Institute for Health and Care Excellence, 2019). Without these supports, expanded pharmacy roles may intensify professional anxiety and role ambiguity rather than strengthen patient care.

The implication for pharmacy education is simple. Undergraduate programmes cannot prepare students only for idealised one-to-one counselling. They must also prepare them to function in imperfect systems, busy dispensaries, fragmented referral networks, variable privacy, and for emotionally complex and distressing cases.

Undergraduate Suicide Prevention Education

Educational literature, while still limited, is encouraging. Student pharmacist interventions consistently report improved knowledge, confidence, comfort, or self-efficacy after training (Willson et al., 2020; Witry et al., 2020; Carpenter et al., 2023; Stover et al., 2023). Importantly, the intervention formats are pedagogically feasible. They include workshops, Question Persuade Refer (QPR) training, brief online modules, interactive video cases, and standardised-patient or scenario-based assessments. This is important because one of the most common objections when considering curriculum development is lack of time; however, the existing literature suggests that meaningful education does not require an entirely separate module or course.

Willson et al. (2020) demonstrated the feasibility of student training that combined knowledge building with a standardised patient prescription-counselling consultation. Witry et al. (2020) found that QPR training improved confidence and knowledge among second-year student pharmacists, with many students reporting the high likelihood of intervening when next confronted with suicide-related warning signs.

Carpenter et al. (2023) demonstrated that a brief training paired with interactive video case assessment improved knowledge and self-efficacy, and that some students later recognised warning signs and reported using elements of the taught framework in practice and real life. Taken together, these studies suggest that undergraduate learners can acquire not only factual knowledge but also a practical willingness to intervene.

Directly asking about suicide evidently remains the hardest communication task. Carpenter et al. (2023) reported that students showed the lowest confidence when asking about suicide compared with validating feelings, referral, and follow-up behaviours. That pattern aligns with the broader training literature and is educationally useful because it identifies a high-value target for deliberate practice. If 'asking directly' is both the most difficult and the most safety-critical skill in suicide prevention, then the pharmacy curriculum should assess it explicitly rather than assuming that general communication training is enough to cover this skill.

Carpenter et al. (2026) undertook a cluster randomised trial of online suicide prevention training for community pharmacy staff. They demonstrated that the training improved knowledge, preparedness, and self-efficacy, and in written cases the proportion of participants who asked about suicide increased from 7% to 71%, while crisis-line referrals increased from 49% to 74%. While simulated outcomes can be limited, there were substantial changes in gatekeepers' behaviour. The trial is important not only because it shows an effect, but because it shows that pharmacy-specific training can be delivered in scalable online formats. When planning a curriculum, therefore, it is a useful reminder that face-to-face teaching can be supplemented rather than replaced.

However, the educational evidence base remains small. Stover et al. (2023) identified only seven relevant training studies in their scoping review and noted that most programmes measured knowledge more often than communication behaviour. Carpenter et al. (2018) highlighted a mismatch between available training resources and formal policy requirements, alongside limited evidence on long-term effectiveness. The



conclusion is not that suicide prevention training lacks value, but that pharmacy education has enough evidence to act, but not enough to be complacent about how teaching is evaluated.

UK educational evidence is beginning to emerge but remains substantially less developed than US literature. Gorton, Elliott and Noonan (2021) reported an evaluation of a 3.5-hour interprofessional suicide prevention session involving student pharmacists and mental health nursing students in the UK. However, this evidence was reported as a conference publication and does not provide the depth of evidence available from larger intervention studies. More recently, O'Driscoll et al. (2026) reported improvements in pharmacy students' suicide prevention skills following a three-hour workshop in Ireland, providing encouraging evidence from a more closely comparable educational and healthcare context. Taken together, these studies support curricular development while simultaneously emphasising the need for larger, longitudinal UK evaluations of suicide prevention education.

Curriculum Integration Recommendations

A convincing curricular response is unlikely to be achieved through a single lecture or isolated workshop. A competency-based spiral approach is proposed in which suicide prevention knowledge, skills and professional behaviours are introduced early, revisited longitudinally, and applied within

progressively more complex practice situations. Spiral curriculum design involves revisiting important topics at increasing levels of complexity, with each encounter building upon previous learning (Harden & Stamper, 1999). This complements competency-based pharmacy education, in which knowledge, skills and attitudes are aligned with authentic teaching, learning and assessment to prepare learners for professional practice (Jarrett et al., 2024). This approach fits pharmacy particularly well because suicide prevention crosses multiple domains already present in degree programmes, including communication, professional practice, ethics, medicines optimisation, public health, urgent care, safeguarding, and mental health therapeutics.

A spiral design would begin with a foundational understanding of why pharmacy is a suicide prevention setting, including accessibility, repeated contact, and medication-related risk. It would then move into communication micro-skills, especially how to ask directly, respond nonjudgementally, and validate distress. Later teaching could situate these skills within workflow processes, referral, documentation, confidentiality, legal and ethical reasoning, and team-based escalation. Advanced stages could integrate lethal means management, case complexity, and post-incident reflection. By the end of training, students should be able not only to recognise and respond to warning signs, but also to design or critique the pharmacy systems that make safe responses possible.



This model aligns well with existing UK educational, professional, and service standards. The General Pharmaceutical Council standards for the initial education and training of pharmacists emphasise patient-centred care and collaboration, professional practice, leadership and management, and education and research, with progression to observed performance in practice. NICE guidance on self-harm and suicide prevention, alongside Royal Pharmaceutical Society policy on mental health and wellbeing, similarly reinforce compassionate communication, safe escalation, and coordinated support across settings (General Pharmaceutical Council, 2021; National Institute for Health and Care Excellence, 2022; National Institute for Health and Care Excellence, 2019; Royal Pharmaceutical Society, 2022). Suicide prevention can be mapped onto these domains without distorting the curriculum and by doing so may strengthen the coherence of the programme by showing students how communication, ethics, and patient safety intersect in real practice.

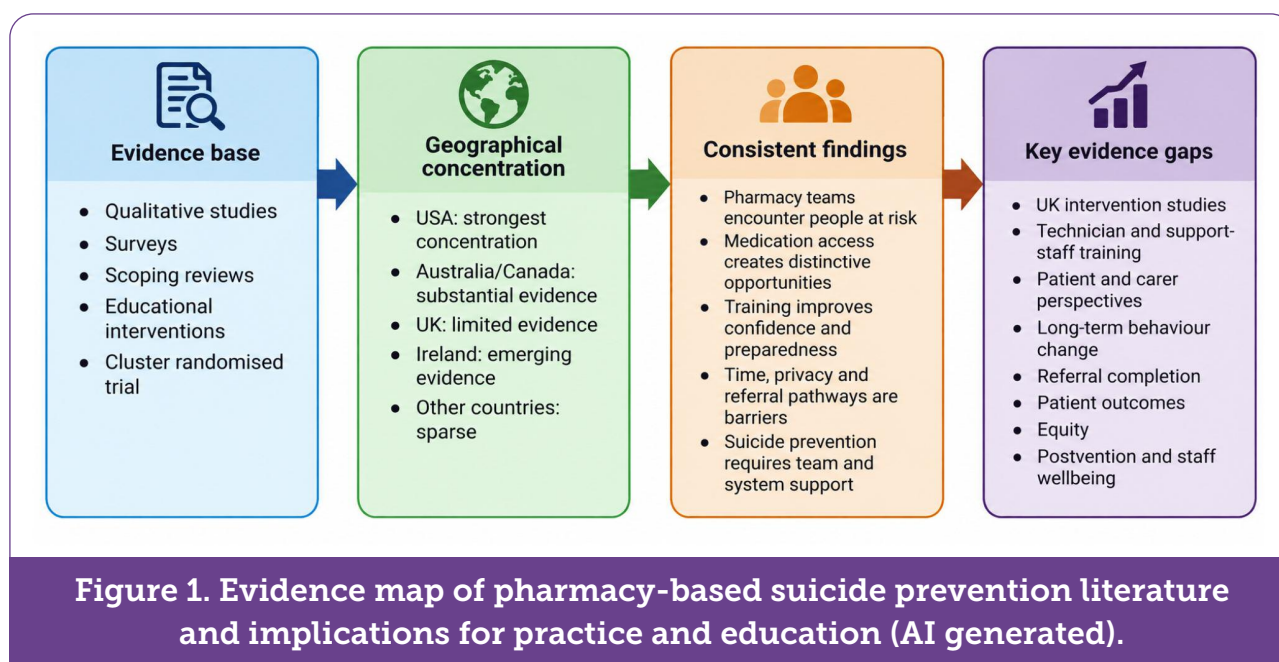
Student assessment must match the intended competence and whilst knowledge tests have a place, they should not dominate student evaluation. The available literature suggests that observed or scenario-based assessments are particularly important because they make hidden communication failures visible. Objective structured clinical examinations (OSCEs), standardised patient encounters, video case analyses, written case responses, documentation exercises, and referral mapping tasks all provide more meaningful evidence of readiness than attitude scales alone. Just as importantly, they signal to students that suicide prevention is a practice capability and not just a topic to be learned.

A further recommendation is to incorporate team-based and system-aware learning. Pharmacy students should practise not only what they would say to a distressed person, but also how they would organise a safe response in a busy pharmacy. That may include scripting the role of front-counter staff, identifying when to move a conversation to a private space, developing local referral lists, rehearsing emergency escalation, and reflecting on how to support colleagues after a critical incident. The qualitative evidence suggests they are central determinants of whether gatekeeping can happen at all (Gorton et al., 2019; O'Driscoll et al., 2023).

Finally, the curriculum should explicitly include postvention and professional wellbeing. The evidence from El-Den et al. (2022) indicates that suicide-related encounters can affect pharmacists personally and professionally yet help-seeking remains limited. UK workforce data reinforces the need to treat staff wellbeing as a system issue, particularly in community pharmacy, where burnout and workplace pressures remain prominent concerns (Royal Pharmaceutical Society and Pharmacist Support, 2023). Programmes that normalise reflective practice, debriefing, and support-seeking may improve both workforce wellbeing and patient safety by reducing the hidden burden of emotionally demanding consultations.

"Across the literature, several consistent patterns emerge. First, pharmacy teams already encounter people experiencing suicidal distress and medication-related risk rather than suicide prevention representing a wholly hypothetical future role. Second, lack of training, uncertain referral pathways, time pressure and privacy constraints recur across countries. Third, educational interventions consistently improve outcomes such as knowledge, confidence, preparedness and simulated gatekeeper behaviour. Fourth, effective gatekeeping appears to depend on the pharmacy system and wider team as much as on the competence of an individual pharmacist."





There are also important conflicts within the evidence. Pharmacy professionals generally recognise a potential contribution to suicide prevention while continuing to express uncertainty about the boundaries of that responsibility. Medication access potentially gives pharmacy a distinctive role in restricting access to lethal means, yet UK qualitative evidence suggests that pharmacy team members do not necessarily recognise this as an established part of their role. Most importantly, improvements in knowledge, self-efficacy and simulated behaviour have not yet been matched by convincing evidence of sustained behaviour change or improved patient outcomes.

These conflicts expose several significant gaps. UK-specific empirical research remains limited, particularly regarding undergraduate education and implementation in routine practice. Pharmacy technicians, dispensers, counter staff and other members of the pharmacy team are insufficiently represented in intervention studies despite their potential first-contact role. Patient and carer perspectives are also largely absent. Further research is required to establish referral completion, patient outcomes, longer-term retention of gatekeeper skills, equity of access, implementation within different pharmacy models and appropriate support for staff following suicide-related encounters.

Figure 1 summarises the distribution of the evidence, the principal recurring findings and the major gaps identified in this narrative synthesis.

Future Research Agenda

It is suggested that this could address three priorities. Firstly, the move from educational outcomes to patient-relevant and practice-relevant outcomes. At present, the best evidence demonstrates improvements in knowledge, confidence, preparedness, and simulated behaviour. What remains less clear is whether training changes what happens in routine consultations, whether referrals are completed, whether follow-up occurs, and whether pharmacy-based intervention reduces repeat self-harm or improves referral to ongoing care.

Secondly, implementation. Qualitative studies have already established a barrier profile including time, privacy, stigma, unclear referral routes, and role ambiguity. Future studies should therefore evaluate which implementation supports make the greatest difference. Examples include but are not limited to local crisis directories, documentation templates, quick-reference prompts, consultation rooms, staff scripts, and employer policies. The pre-implementation work by Lavigne et al. (2025) is particularly valuable because it shifts the conversation from whether pharmacies could contribute to how they might do it sustainably.

Thirdly, current evidence is concentrated in a small number of countries and practice models. We know comparatively little about how pharmacy-based suicide prevention is experienced by patients



and carers, how stigma and confidentiality concerns shape help-seeking in different communities, or how legal and service structures alter what is feasible across different authorities. Research should also examine whether curricular interventions prepare students equally well across varied backgrounds and whether pharmacy-led strategies reduce or inadvertently widen disparities in access to crisis support.

Additional educational research questions are potentially immediately implementable. Which sequences of teaching best improve observed performance? How much repetition is needed for difficult skills such as asking directly about suicide? What faculty development is required for consistent, psychologically safe assessment and feedback? How should mentors be prepared to supervise these conversations in practice placements? If we are serious about pharmacy as a suicide prevention setting, and we should be, we need answers not only about what to teach, but also about how educational systems make that teaching successful and sustainable for the future.

Conclusion

Suicide prevention capability in pharmacy is achievable, but it will not emerge reliably on its own. The literature already shows that pharmacy teams encounter suicide warning signs, medication-related crises, and requests that place them in a gatekeeping position. It also shows that tailored training can improve knowledge, preparedness, self-efficacy, and simulated gatekeeper behaviour. At the same time, the literature shows that time pressure, privacy constraints, unclear pathways, role ambiguity, and inadequate support remain persistent barriers.

For that reason, the pharmacy sector should stop treating suicide prevention as an optional add-on and instead recognise it as a patient-safety capability that sits naturally within contemporary pharmacy practice. Initial pharmacist education is an important opportunity to establish this capability in future pharmacists, but it represents only one component of a wider workforce approach. A competency-based, spiral, and team-aware curriculum can build communication, judgement, referral, and systems-thinking skills required for safe suicide-prevention gatekeeping.

The next step is to couple educational ambition with implementation science, organisational support, and outcomes research so that pharmacy's contribution to suicide prevention becomes not only plausible, but dependable and valuable. Suicide prevention capability should also extend to pharmacy technician education, support-staff training and continuing professional development across the pharmacy workforce, with expectations tailored to role and scope of practice.

References

- Carpenter, D. M., Lavigne, J. E., Roberts, C. A., Zacher, J., & Colmenares, E. W. (2018). A review of suicide prevention programs and training policies for pharmacists. *Journal of the American Pharmacists Association: JAPhA*, 58(5), 522–529. <https://doi.org/10.1016/j.japh.2018.05.004>
- Carpenter, D. M., Lavigne, J. E., Colmenares, E. W., Falbo, K., & Mosley, S. L. (2020). Community pharmacy staff interactions with patients who have risk factors or warning signs of suicide. *Research in social & administrative pharmacy: RSAP*, 16(3), 349–359. <https://doi.org/10.1016/j.sapharm.2019.05.024>
- Carpenter, D. M., Stover, A. N., Harris, S. C., Anksorus, H., & Lavigne, J. E. (2023). Impact of a Brief Suicide Prevention Training with an Interactive Video Case Assessment on Student Pharmacist Outcomes. *American journal of pharmaceutical education*, 87(7), 100093. <https://doi.org/10.1016/j.ajpe.2023.100093>
- Carpenter, D. M., Stover, A., Shackley, A. G., Tudor, G., Cross, W., Marley, G., ... & Lavigne, J. E. (2026). The impact of an online suicide prevention training program on community pharmacy staff outcomes: A cluster randomised trial. *Journal of the American Pharmacists Association*, 103038. <https://doi.org/10.1016/j.japh.2026.103038>
- Department of Health and Social Care. Suicide prevention strategy for England: 2023 to 2028. London: DHSC; 2023.
- El-Den, S., Choong, HJ., Moles, R.J. et al. Exploring the impact of suicide care experiences and post-intervention supports sought among community pharmacists: a cross-sectional survey. *Int J Clin Pharm* 44, 1247–1258 (2022). <https://doi.org/10.1007/s11096-022-01398-4>
- General Pharmaceutical Council. Standards for the initial education and training of pharmacists. London: GPhC; 2021.
- Gorton, H., Elliott, R. & Noonan, I. (2021). Student pharmacists and mental health nurses training together in suicide prevention: an evaluation of interprofessional education. *International Journal of Pharmacy Practice*, 29(Supplement 1), i13–i14. <https://doi.org/10.1093/ijpp/riab016.017>
- Gorton, H. C., Littlewood, D., Lotfallah, C., Spreadbury, M., Wong, K. L., Gooding, P., & Ashcroft, D. M. (2019). Current and potential contributions of community pharmacy teams to self-harm and suicide prevention: A qualitative interview study. *PLOS ONE*, 14(9), e0222132. <https://doi.org/10.1371/journal.pone.0222132>
- Harden, R.M. & Stamper, N. (1999). What is a spiral curriculum? *Medical Teacher*, 21(2), 141–143. <https://doi.org/10.1080/01421599979752>



Jarrett, J.B., Elmes, A.T., Keller, E., Stowe, C.D. & Daugherty, K.K. (2024). Evaluating the strengths and barriers of competency-based education in the health professions. *American Journal of Pharmaceutical Education*, 88(6), 100709.

<https://doi.org/10.1016/j.ajpe.2024.100709>

Kamal, L., & Jacob, S. A. (2023). Pharmacists' Experiences, Perceptions, and Attitudes towards Suicide and Suicide Prevention: A Scoping Review. *Pharmacy*, 11(1), 25.

<https://doi.org/10.3390/pharmacy11010025>.

Lavigne JE, et al. Lethal means management innovations in community pharmacies: A preimplementation study in 6 states. *Journal of the American Pharmacists Association*.

2025;65(5):102458. <https://doi.org/10.1016/j.japh.2025.102458>

Murphy AL, Hillier K, Ataya R, et al. A scoping review of community pharmacists and patients at risk of suicide. *Canadian Pharmacists Journal / Revue des Pharmaciens du Canada*.

2017;150(6):366-379. <https://doi.org/10.1177/1715163517733482>

National Institute for Health and Care Excellence. Self-harm: assessment, management and preventing recurrence (NG225). London: NICE; 2022.

National Institute for Health and Care Excellence. Suicide prevention (QS189). London: NICE; 2019.

NHS England. Pharmacy First. London: NHS England; 2024.

O'Driscoll, M., O'Mahony, C., Keating, E., O'Regan, N., & Sahm, L. J. (2023). Interacting with patients at risk of self-harm or suicide - A qualitative study of community pharmacists and pharmacy staff. *Exploratory research in clinical and social pharmacy*, 11, 100293.

<https://www.sciencedirect.com/science/article/pii/S2667276623000744?via%3Dihub>

O'Driscoll, M., Gallagher, K., Donovan, M., Sahm, L., Fleming, A., O'Brien, C., O'Neill, A., & Griffin, E. (2026). Suicide prevention training for pharmacy students in Ireland: A pre-post survey evaluation. *Exploratory Research in Clinical and Social Pharmacy*, 100839. <https://doi.org/10.1016/j.rcsop.2026.100839>

O'Reilly, C. L., Wong, E., & Chen, T. F. (2015). A feasibility study of community pharmacists performing depression screening services. *Research in social & administrative pharmacy: RSAP*, 11(3), 364-381

<https://www.sciencedirect.com/science/article/abs/pii/S1551741114003179?via%3Dihub>

Royal Pharmaceutical Society. The role of pharmacy in mental health and wellbeing. London: RPS; 2022.

Royal Pharmaceutical Society, Pharmacist Support. Workforce and Wellbeing Survey 2023. London: RPS; 2023.

Stover, A. N., Lavigne, J. E., & Carpenter, D. M. (2023). A Scoping Review of Suicide Prevention Training Programs for Pharmacists and Student Pharmacists. *American journal of pharmaceutical education*, 87(3), ajpe8917. <https://doi.org/10.5688/ajpe8917>

Willson, M. N., Robinson, J. D., McKeirnan, K. C., Akers, J. M., & Buchman, C. R. (2020). Training Student Pharmacists in Suicide Awareness and Prevention. *American journal of pharmaceutical education*, 84(8), ajpe847813.

<https://doi.org/10.5688/ajpe847813>

Witry M, Kauer, J., Fravel, M., Reist, J., & Viyyuri, B. (2020). Evaluation of a Question Persuade Refer (QPR) training for student pharmacists. *Mental Health and Prevention*. 18:200180.

<https://doi.org/10.1016/j.mhp.2020.200180>





As a reader of PM Healthcare Journal, stay connected by following us on LinkedIn and discovering our new blog (<https://www.pmhealthcare.co.uk/blog/>)

We regularly post commentary and opinions on pharmacy, the NHS and healthcare across the UK, and also updates on articles and features in PM Healthcare Journal. Join us on social media to keep up to date with:

- 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:

John Chater, Editor – PM Healthcare Journal E: editor@pmpublications.co.uk



Leading Through Trauma: Why One Size Doesn't Fit All in Pharmacy



Rachael Lemon,
Executive Coach | Honorary Member, Royal College of Pharmacy | NHS Leadership
Email: Hello@rachaellemon.com

About the author

Rachael Lemon is an executive leadership coach, consultant and trauma advocate, and founder of Lemon AID Coaching & Consultancy. With more than 30 years in healthcare and over 20 years in senior, executive and board-level leadership, she has worked across the NHS, government, industry and national healthcare programmes, including NHS England and the Department of Health.

An Honorary Member of the Royal Pharmaceutical Society for distinguished services to pharmacy, Rachael now specialises in trauma-informed and neuro-affirming leadership, working with senior leaders and organisations across healthcare and beyond.

A domestic abuse survivor with specialist training in trauma-informed practice and rape crisis work, she brings together lived experience, professional expertise and decades of healthcare leadership. She is also Editor-in-Chief of EmpowHER, a publication amplifying women's voices across healthcare, leadership and wider society.

Connect on LinkedIn:

[linkedin.com/in/rachaellemon-leadership-coach-mentor](https://www.linkedin.com/in/rachaellemon-leadership-coach-mentor)

"Racism isn't the shark. Racism is the water the shark swims in."

I've used that line in my own writing about racism. It's my interpretation of an idea I first encountered through spoken-word artist Guante's poem *How to Explain White Supremacy to a White Supremacist*. His original line is starker: "White supremacy is not a shark; it is the water."

The shark is easier to see. An individual act of racism. Discrimination. Abuse. Violence. The water is harder to see because it's all around us. It's the systems, structures and institutions that shape what happens before, during and after those individual acts.

I've come to see domestic abuse in much the same way.

We focus, understandably, on individual perpetrators. We prosecute them, restrain them and, where the criminal justice system works as it should, imprison them. Those interventions matter. They don't change the water.

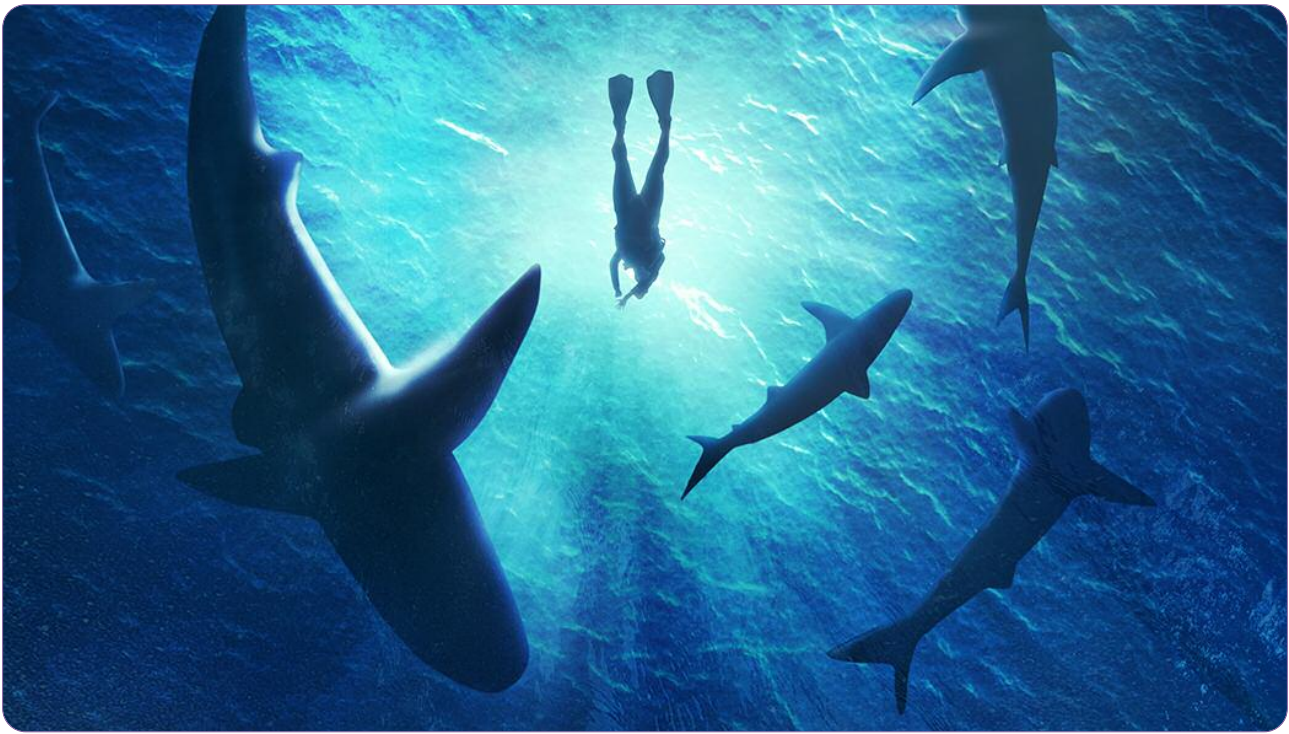
The water is everything a survivor has to navigate while trying to stay safe. It's the workplace that interprets a trauma response as a performance problem. The policy that looks compassionate until somebody actually needs to use it. The service designed around an imaginary person with money, transport, somewhere safe to live and the capacity to navigate a complicated system while experiencing trauma.

Pharmacy isn't somehow outside that water.

Over this series, I've explored what trauma-informed practice means for our profession. I've looked at what happens when our own experiences meet somebody else's trauma, how workplace systems can compound harm, and what it takes to create environments where people feel safer.

There is another layer we need to address. Trauma doesn't affect everyone equally because none of us experiences the world through a single part of who we are.





When one size doesn't fit all

In 1989, American legal scholar Kimberlé Crenshaw coined the term intersectionality while examining how Black women's experiences of discrimination could disappear when racism and sexism were considered separately. The framework gave language to something our policies still too often miss: that different parts of our identity and circumstances don't operate independently of one another.

Race, gender, disability, sexuality, neurodivergence, poverty and immigration status don't queue politely and affect us one at a time. They intersect. The barriers created at those intersections can be different from those created by any one factor alone.

In pharmacy, those intersections affect both the people using our services and the people providing them.

The same workplace policy can be available to every member of staff and still be inaccessible to some of them. The same service can be offered to every patient and still be harder for some people to use. Treating people equally doesn't automatically remove the barriers that brought them to the pharmacy in the first place.

Take domestic abuse. A workplace policy might

offer every employee exactly the same route to support. Yet the person trying to use it may also be disabled, financially dependent on their perpetrator, worried about their immigration status, experiencing racism, parenting children or carrying previous experiences of institutions that have failed them. Those aren't separate problems that can conveniently be dealt with one at a time. They affect whether that person can use the support we're offering at all.

"The boundaries are not as neat as our policies sometimes assume either. The pharmacist supporting a patient through trauma may be living with trauma themselves. The pharmacy leader responsible for supporting their team is still an employee, a patient, a partner, a parent or a survivor outside work. Sometimes they are several of those things at once."





Equality on paper isn't necessarily equity in practice.

A trauma-informed approach has to recognise the difference. Otherwise, we risk building systems that work best for the people who already find them easiest to navigate.

What does that look like in practice?

Across my work in healthcare, leadership, coaching and trauma advocacy, I've supported people living through these intersections rather than simply reading about them.

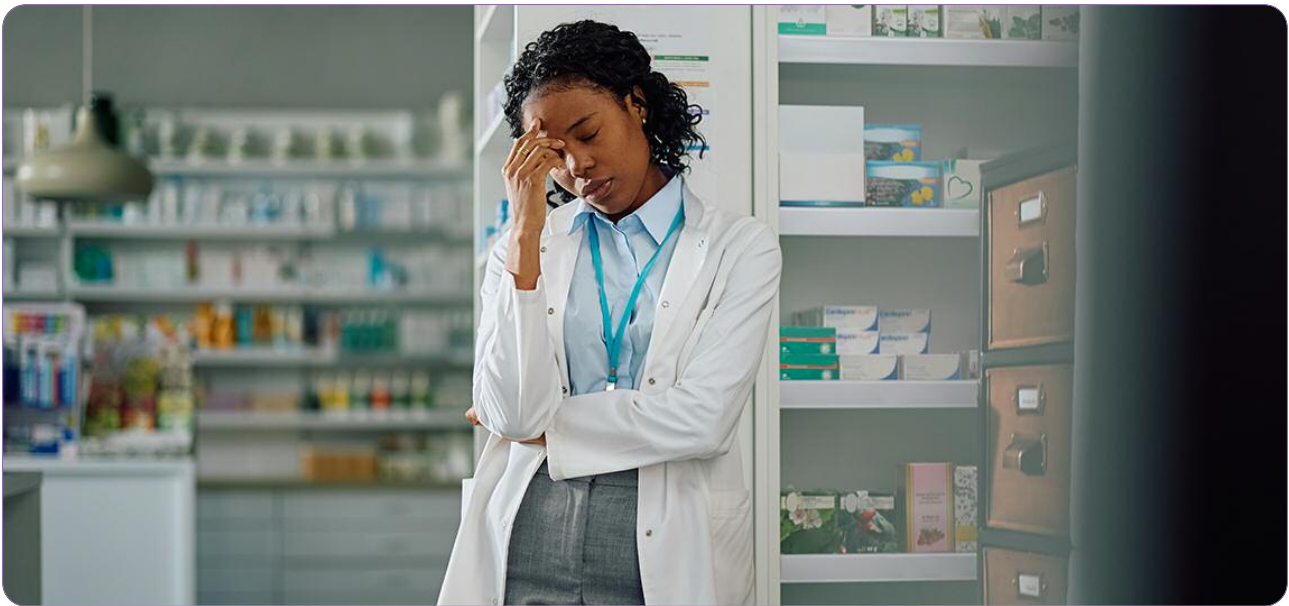
I've worked with women experiencing domestic abuse whose immigration status affected the choices available to them. Women navigating racism alongside trauma. Disabled and neurodivergent professionals whose requests for support became entangled with questions about their performance or capability. Women trying to remain credible professionals at work while dealing with circumstances their colleagues knew nothing about.

Many of the women I've supported are from minoritised communities. Their experiences aren't interchangeable, and neither are the barriers they face.

"Women are disproportionately affected by domestic and sexual violence, which is reflected in both my work and the evidence. They aren't the only victims. I've also supported men who have experienced abuse and sexual violence, and they can face different barriers to disclosure, support and being believed. Trauma-informed practice has to leave room for both truths."

Consider a pharmacist experiencing domestic abuse whose immigration status is connected to





their relationship. A workplace policy might tell them that support is available and provide information about leaving. On paper, the organisation has responded appropriately.

In real life, that pharmacist may be calculating something quite different. Where can I live? What happens to my immigration status? What money can I access? Who can I safely tell? Will I be believed? What happens to my children? Could asking for help make me less safe?

Or consider a pharmacist who discloses a disability or neurodivergence and asks for reasonable adjustments. The policy exists. The organisation may even describe itself as inclusive. Yet if those adjustments are delayed, inconsistently implemented or treated as an inconvenience, the resulting difficulties can later be interpreted as evidence that the individual cannot cope with their role.

A Black pharmacist experiencing racism at work faces another calculation. Reporting an incident isn't simply a matter of knowing where the HR policy lives. It means deciding whether they expect to be believed, what challenging the behaviour might mean for their career, and whether speaking up will change the behaviour or simply change how colleagues perceive them.

These are the things an equality policy cannot tell you.

A pharmacist can be highly qualified, professionally

successful and outwardly coping while simultaneously navigating abuse, racism, disability, financial control, caring responsibilities or trauma. They can be the healthcare professional supporting somebody else's vulnerability at ten o'clock and the person who needs support themselves by lunchtime.

Being a healthcare professional doesn't make us immune to the things our patients experience. Sometimes we're supporting someone through something we're also living through ourselves.

A policy can exist. A service can exist. A legal right can exist. None of those things automatically makes it accessible to the person who needs it.

The glass cliff

There is another pattern worth understanding when we talk about who gets opportunities to lead.

In 2005, psychologists Michelle Ryan and Alex Haslam coined the term glass cliff after examining appointments to FTSE 100 company boards. They found that, during a period of overall stock-market decline, companies appointing women were more likely to have experienced consistently poor performance in the preceding months than companies appointing men.

The glass ceiling describes the barriers that can



prevent women from reaching senior positions. The glass cliff asks a different question:

“What kind of leadership position is waiting when they finally get there?”

Sometimes, it is a precarious one.

Research since then has produced a more complicated picture rather than a universal rule. A 2020 meta-analysis found evidence of a small glass-cliff effect for women, although it varied according to organisational context. It also found evidence extending the phenomenon to people from underrepresented racial and ethnic groups.

The point isn't that every woman or minoritised leader appointed during a crisis has been deliberately set up to fail. Getting through the glass ceiling doesn't necessarily mean the playing field suddenly becomes level.

I've seen versions of this throughout my own professional life: talented people given responsibility for teams, services or projects already in difficulty, then judged on whether they can fix problems that existed long before they arrived.

“Think about what that could mean in pharmacy. A department is understaffed. Morale is poor. Demand is rising. Resources are stretched. Someone is finally given the senior opportunity they have worked towards.”

What are we actually giving them?

A promotion, or responsibility for an impossible problem?

Representation matters. Who gets the authority, resources, support and time to succeed matters too.

Otherwise, we risk celebrating who has reached the top without looking closely enough at where we've asked them to stand.

Beyond Equal Treatment

Trauma-informed leadership recognises different starting points.

It's not enough to say, “we treat everyone equally.” Equal treatment in unequal circumstances can perpetuate inequality.

Two people can experience the same trauma and need very different things from us. Their financial circumstances, disability, race, immigration status, sexuality, caring responsibilities, previous experiences of services and the support available around them can all affect what happens next.

The same is true at work. Two pharmacy professionals can be offered exactly the same support and have completely different access to it. One may have the financial security, knowledge of the system and existing relationships to challenge a decision or ask for help. Another may be calculating whether speaking up could affect their income, immigration status, career progression, safety or how they are perceived professionally.

Treating those people identically isn't necessarily fair.

This isn't “special” treatment. It's what equity actually means: recognising what somebody needs in the context of the barriers they are facing, rather than assuming the same response will work for everyone.

The £250 Reality

Some organisations have offered £250 emergency payments for women fleeing domestic abuse.

Sounds supportive, doesn't it?

It was. For someone who needed money immediately to get away, £250 could make a very real difference.

The problem isn't the £250. It's what happens when we assume that giving everybody the same amount means we've given everybody the same opportunity to reach safety.

For someone with their own income, access to transport, family or friends nearby and somewhere safe to stay, £250 might bridge the immediate gap while they access other support.



STOP DOMESTIC VIOLENCE



Now change the starting point.

Someone has no independent access to money. They have children to take with them. Perhaps they need accessible accommodation. Perhaps their immigration status affects their entitlement to public funds. Perhaps their perpetrator controls their bank account, phone or documents.

The payment hasn't changed.

Their ability to use it has.

Same support. Vastly unequal impact.

Equity doesn't mean the £250 shouldn't be offered. It means the conversation cannot end there.

What else stands between this person and safety? Housing? Immigration advice? Accessible services? Childcare? Money? Transport? Somewhere their perpetrator cannot find them?

That's the difference between designing a policy that looks supportive and building support that works when somebody actually needs it.

Survivor-Led Design

I'm part of a survivor-led initiative building community-based support. We're designing systems around lived experience, not theory.

Here's what we learned immediately: lived experience is crucial. Not just any lived experience. Diverse lived experience.

The white professional woman who has left domestic abuse and rebuilt her life has valuable insight. I know, because that's part of my own story. It doesn't mean I can speak for an immigrant woman with no recourse to public funds, a disabled woman navigating inaccessible services, an LGBT+ survivor facing different barriers, or a woman experiencing racism alongside abuse.

Survivor-led doesn't mean finding one survivor and asking them to speak for everyone.

It means bringing people with different experiences into the design of services early enough to change them. It means listening when somebody tells us that something we've designed won't work for them. It means recognising that professional expertise and lived experience tell us different things, and we need both.

It also means paying survivors for their expertise.

We wouldn't expect a consultant to hand over their professional knowledge for free. Yet survivors are routinely asked to tell deeply personal stories, sit on panels, review services and educate organisations in return for having their "voice heard".



Lived experience is expertise. We shouldn't extract it for free.

There is something else survivor-led practice has to protect: ownership.

"Disclosure isn't permission to retell somebody's story." Rachael Lemon

Being trusted with someone's trauma doesn't make it ours to use. People should retain control over what they share, how it is shared and whether it is shared at all.

That principle matters in healthcare too, where we can be trusted with extraordinarily personal information simply because of the role we hold.

"Nothing about us without us" shouldn't be something we put on a slide. It should change who gets heard, who gets paid for their expertise and who has power when decisions are made.

From Policy to Practice

A trauma-informed approach changes more than the words in a policy. It changes how we design services, manage people and make decisions.

Design with people, rather than for them. If a policy or service is intended to support people experiencing domestic abuse, disability, racism or other forms of inequality, involve people with those experiences before the decisions have already been made. Ask what doesn't work as well as what does.

Then look at who isn't using the support you've created.

A policy can have good uptake overall and still be failing particular groups. Who accesses it? Who drops out? Who never comes forward in the first place? What happens after somebody asks for help?

Apply the same questions to your workplace.

An organisation can have a domestic abuse policy, a reasonable adjustments process, a wellbeing programme and an impressive inclusion statement. None of those tells us what happens to the person who tries to use them.

Do reasonable adjustments actually happen? Are concerns about racism or discrimination taken

seriously? Can somebody disclose domestic abuse without fearing that it will affect how they are perceived professionally? What happens when somebody's circumstances don't fit neatly into the process we've designed?

Who gets to answer those questions matters.

"People who have spent their careers navigating systems that weren't designed with them in mind often see things others don't. A disabled colleague may recognise an access barrier before anyone else in the room. A neurodivergent pharmacist may spot assumptions built into how work is organised. Someone who has experienced racism may recognise a pattern that colleagues who haven't experienced it simply don't see."

That doesn't make any individual responsible for representing an entire community. Nobody should have to disclose personal experiences to earn the right to influence a decision.

It does mean we need to notice whose knowledge is missing when decisions are made.

Representation alone isn't enough. The glass-cliff research gives us another question to ask. Once somebody gets through the door, what are we asking them to walk into?

Do they have the authority, resources and support to change anything? Are different perspectives genuinely influencing decisions? Or have we changed who is sitting around the table without changing who holds the power?

This doesn't require another policy.





It requires us to ask better questions.

Instead of only asking, “Do we have a policy?”, ask “What happens when somebody tries to use it?”

Instead of “Is this service available to everyone?”, ask “Who still can’t access it, and why?”

Instead of “Did we consult people with lived experience?”, ask “What changed because we listened?”

Instead of “Who have we included?”, ask “Who is still missing?”

Ultimately, a policy isn’t trauma-informed because of what it says.

It’s trauma-informed because of what happens to the person who needs it.

When people start talking

Since this series began, pharmacists and other healthcare professionals have contacted me privately to share their own experiences.

Some have recognised themselves in what I’ve written. Some have disclosed experiences of domestic or sexual abuse and other trauma. Others have talked about what happens when a patient shares something deeply traumatic with them,

sometimes unexpectedly, in the middle of an otherwise ordinary working day.

Those conversations have reinforced something I’ve written about throughout this series: the person supporting someone else’s trauma may be carrying trauma of their own.

We ask healthcare professionals to notice. To listen. To create safety. To respond appropriately when somebody discloses abuse or trauma.

What happens to them afterwards?

Where does a community pharmacist go after hearing something they can’t simply unhear? What happens when a patient’s disclosure touches something in their own history? Where is the confidential space to process the impact without compromising the patient’s privacy or making their story somebody else’s to tell?

For some healthcare professionals, supervision provides somewhere to take difficult experiences. In pharmacy, supervision increasingly forms part of prescribing, training and some clinical roles. But I haven’t found an equivalent, routinely available space for pharmacists to process the emotional impact of receiving disclosures of abuse and trauma.



And as the clinical role of community pharmacy expands, I think that's a conversation we need to have.

I've been looking for the answer to that question. I haven't found one that satisfies me yet.

And perhaps that's where this series needs to end. Not with another list of things pharmacy professionals should do, but with something our profession needs to ask.

If we want healthcare professionals to create safe spaces for other people's trauma, where are the safe spaces for them?

Trauma-informed practice cannot only be about becoming better at receiving disclosure. We also need to think about what happens after it has been received.

This work doesn't end with this article. If anything, I think this is where the next part begins.

Discussion Points for Your Team

Who might find it hardest to use the policies and support we already have in place, and why?

When someone asks for support, are we offering everybody the same thing or considering what they actually need?

Whose lived experience is missing when services and workplace policies are designed?

When people from underrepresented groups move into leadership roles, do they have the authority, resources and support to succeed?

What changes when somebody shares an experience of trauma or abuse with a member of our team?

And who supports the healthcare professional after they have received that disclosure?

Further Reading and References

Crenshaw, K. (1989). *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*. University of Chicago Legal Forum, 1989, Article 8.

<https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8/>

Ryan, M.K. & Haslam, S.A. (2005). *The Glass Cliff: Evidence that Women are Over-Represented in Precarious Leadership Positions*. British Journal of Management, 16(2), 81–90.

<https://onlinelibrary.wiley.com/doi/10.1111/j.1467-8551.2005.00433.x>

Morgenroth, T., Kirby, T.A., Ryan, M.K. & Sudkämper, A. (2020). *The who, when, and why of the glass cliff phenomenon: A meta-analysis of appointments to precarious leadership positions*. Psychological Bulletin, 146(9), 797–829.

<https://pubmed.ncbi.nlm.nih.gov/32700940/>

NHS England (2026). *Commissioning guidance for community pharmacy prescribing-based services*. Includes guidance on clinical/professional supervision for independent prescribing pharmacists working in community pharmacy.

<https://www.england.nhs.uk/long-read/commissioning-guidance-for-community-pharmacy-prescribing-based-services/>

NHS England (2023). *Supervision guidance for primary care network multidisciplinary teams*. Includes clinical/professional and peer supervision, including supervision for clinical pharmacists.

<https://www.england.nhs.uk/long-read/supervision-guidance-for-primary-care-network-multidisciplinary-teams/>

NHS England (2026). *Professional assurance framework for delivering NHS community pharmacy clinical services*.

<https://www.england.nhs.uk/publication/professional-assurance-framework-for-delivering-nhs-community-pharmacy-clinical-services/>

Home Office (2023). *Victims fleeing domestic abuse given lifeline payments*.

<https://www.gov.uk/government/news/victims-fleeing-domestic-abuse-given-lifeline-payments>



Office for National Statistics (2025). *Domestic abuse victim characteristics, England and Wales: year ending March 2025*.
<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2025>

Office for National Statistics (2025). *Sexual offences victim characteristics, England and Wales: year ending March 2025*.
<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/sexualoffencesvictimcharacteristicsenglandandwales/latest>

Myhre, K. "Guante" T. (2016). *How to Explain White Supremacy to a White Supremacist*.
<https://guante.info/2016/03/17/how-to-explain-white-supremacy-to-a-white-supremacist-new-video/>

Previous Articles in This Series

The Professional's Blind Spot

Why trauma-informed care starts with recognising your own trauma responses.

PM Healthcare Journal, Winter 2026, Issue 15.

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

PM Healthcare Journal, Spring 2026.

Building Trauma-Informed Teams

Moving from policy to practice in creating genuinely supportive pharmacy environments.

PM Healthcare Journal, Summer 2026.

Further Reading from Rachael Lemon

The Day I Learned We're All Swimming in Water We Can't See

<https://www.linkedin.com/pulse/day-i-learned-were-all-swimming-water-we-cant-see-rachael-lemon--6vn6e>

What Happened When I Told People I'd Left

<https://www.linkedin.com/pulse/what-happened-when-i-told-people-id-left-rachael-lemon--i0qec>

The Day I Read Someone Else's Story and Couldn't Pretend Anymore

<https://www.linkedin.com/pulse/copy-day-i-read-someone-elses-story-couldnt-pretend-anymore-lemon--lgaae>

The Devil Walks Amongst Us and He's Closer Than You Think

<https://www.linkedin.com/pulse/devil-walks-amongst-us-hes-closer-than-you-think-rachael-lemon--fe7ae>

Perpetrators Are Rarely Charged. Women Get A Life Sentence Then Are Medicalised For Their Trauma

<https://www.linkedin.com/pulse/perpetrators-rarely-charged-women-get-life-sentence-trauma-lemon--a4yoe>

The Shame's Not Ours To Carry

<https://www.linkedin.com/pulse/shames-ours-carry-rachael-lemon--f853e>



