th'scovery

Health Education Foundation

NPA NATIONAL PHARMACY ASSOCIATION

Deliberative Roundtable: Independent Prescribing in Community Pharmacy

Post-Event Summary

September 2026

Deliberative Roundtable: Independent Prescribing in Community Pharmacy

Post-event summary note

Key outcomes, stakeholder feedback and agreed refinements to the draft Framework

Date	15 July 2026, 12.00–15.30
Venue	The Royal Society of Medicine, 1 Wimpole Street, London W1G 0AE
Delivered by	National Pharmacy Association (NPA), NPA Health Education Foundation, Thiscovery and Q
Chair	Sukhi Basra, Vice Chair, National Pharmacy Association
Attendance	29 participants, drawn from community pharmacy, primary care, NHS England and the devolved nations, professional and regulatory bodies, and patient representative organisations, plus the core project team (See Appendix A for a list of attendees).
Ground rules	Discussion held under the Chatham House Rule. Comments in this note are therefore reported thematically and are not attributed to individuals or organisations.
Sources	Three independent facilitator transcripts, two note-takers' records of the plenary and small-group discussion, and anonymous written responses submitted via live polling during both discussion sessions.

1. Foreword

Independent prescribing represents one of the greatest opportunities community pharmacy has had in many years, although significant obstacles to roll-out remain. As more pharmacists qualify as prescribers, we have a great chance to bring more care out of hospital and into the community, to improve access for patients and make better use of capacity across the health system. I have seen the difference this can make in my own practice. As a prescriber, I am able to support patients in ways that were not previously possible. Consultations that might once have required a referral or a long wait can now be completed there and then. When that potential is considered across thousands of pharmacies, the benefit for patients and the NHS could be enormous. But potential alone is not enough, and this opportunity will not be realised without the right support.

The **National Pharmacy Association** is leading a landmark research project to understand what needs to be in place for independent prescribing in community pharmacy to grow safely, consistently and sustainably. The aim is to move beyond recognising the opportunity and set out a clear way forward for making it work in practice. So far, we have heard directly from pharmacists, other primary care professionals, commissioners and patients. Their views have highlighted both the enthusiasm for independent prescribing and the practical issues that still need to be addressed.

Senior figures from the NHS, frontline practitioners including pharmacists and GP colleagues from the Doctors' Association UK and the Royal College of General Practitioners, pharmacy leaders, patient representatives and specialist Health policy researchers from across the UK gathered in London in July to validate findings from initial survey-based research and start mapping out practical recommendations for Government, NHS commissioners and healthcare professionals.

People brought different perspectives, but there was a strong shared commitment to improving patient care and making independent prescribing work well in practice. The discussion also underlined how important the working relationship between community pharmacy and general practice will be to getting this right. I am very grateful to everyone who gave their time and contributed so thoughtfully at this event.

We can now accelerate the next stages of the project, to develop a practical framework and roadmap for pharmacist prescribing that offers real-world support to the pharmacy community, and to improve patient care and shift more clinical services into the community.

Sukhi Basra
Vice Chair, NPA

2. Purpose and format

The roundtable was convened to (i) share and validate findings from the three linked surveys of pharmacists, other primary care professionals and patients on independent prescribing (IP) in community pharmacy (482 total participants: 187 pharmacists, 76 other professionals and commissioners, 219 patients), and (ii) test and refine a draft national Framework, developed by Q with the NPA, setting out the conditions needed for IP to expand safely and sustainably.

Lorna Jacobs (Thiscovery) presented the survey findings; Victoria Treadway (Q) presented the draft Framework. (You can see the draft framework presented at the event in Appendix B). Attendees were organised into multidisciplinary groups around the table, with a patient representative included in each group to keep the patient voice present throughout, and each group was asked to respond to specific questions in turn before opening to others to share their thoughts. The event closed with the Chair's final reflections and comments.

Alongside the room discussion, attendees submitted anonymous written responses via live polling after each presentation; these are referenced separately in Section 7, as they surfaced some points not raised out loud. The session was explicitly framed as a working session to improve the Framework, not to validate it.

This note is compiled from three independent facilitator transcripts, two note-takers' records, and the anonymous poll responses; where sources described the same point in different words, they have been merged, and no individual comment has been attributed to a named attendee or organisation, consistent with the Chatham House Rule agreed on the day.

3. Headline outcomes

The research findings

- The research findings were broadly recognised as an accurate reflection of current experience across all attendee groups, including the devolved nations, though several attendees, both in the room and in the anonymous poll, repeated a concern that the sample of other professionals, and the 15 GP respondents in particular, was too small to be a definitive evidence base.

The framework

- The draft Framework's overall architecture, with three interconnected 'spheres' of conditions (structural, relational and confidence), drawing on principles of systems change, was endorsed as a sound starting point and not something attendees wanted to unpick.

- The strongest and most consistent call, repeated across small groups and the poll, was to make the patient perspective more explicit and more continuously present in the Framework, rather than an assumed constant at its centre.
- A clear, specific ask emerged to add a fourth, outcomes-focused layer to the model, which would wrap around the three existing spheres. This would be to answer 'what is the benefit to the system?' and 'how will we know it is working?' Within this, attendees also discussed distinguishing the outcomes and benefits for patients from those for the wider health system, while showing how the two are connected. These aspects need to be addressed early and not retrofitted.
- Attendees want the Framework to function as a living document that supports implementation expressed as an outcomes-based maturity matrix rather than a static, binary checklist, and applicable differently at micro (organisation), meso (system/region) and macro (national) level.

The independent prescribing offer

- There was strong support for a nationally set minimum standard or baseline independent prescribing offer, paired with local flexibility in delivery, to avoid inconsistent patient access to IP across the country ("a postcode lottery"), and a clearly identified gap around who provides practical implementation support to make this happen locally.

4. Discussion following the research findings

Resonance with lived experience. Findings were described as consistent with day-to-day reality in community pharmacy and primary care, including in Scotland, Wales and Northern Ireland, where IP is more established. The biggest single takeaway repeated across the room and the poll was the gap between professional readiness (pharmacists feel ready) and perceived readiness among other professions and the public, with several describing this as fundamentally a trust and visibility problem rather than a genuine competence gap.

Sample robustness. Several attendees, particularly from general practice representative bodies, felt the number of GP respondents (15) was too small to be a reliable evidence base, and cautioned against over-reading a 'vocal minority' as representative of GP opinion generally. This was raised repeatedly in the anonymous poll on the findings, alongside a related concern that the patient sample and the survey's framing may have leaned towards the positive rather than surfacing negative views fully. There was a clear request for further, more active recruitment of GPs, patients and other professional groups before the findings are used more widely.

Patients and Pharmacy First. Patients were felt to value the convenience of pharmacist prescribing, but awareness had been a 'flash in the pan' rather than a sustained campaign, and a consistent public message is needed. Privacy of consultations was raised repeatedly as a source of patient frustration and an important condition for trust. Several attendees noted, separately, that pharmacy closures are already reducing patients' access to local pharmacies, which is a risk to the expansion ambition itself, not just to its delivery.

Shared records and IT. Attendees agreed that integrated IT and shared access to patient records is central to safe scaling, but flagged that what patients understand and expect around record-sharing needs testing directly with them, rather than assumed, and that ongoing GP industrial action adds further complexity to record access in the short term. This discussion also raised a further question for the Framework to address directly: what level and type of record access community pharmacist prescribers themselves would need to support safe prescribing and continuity of care, for example, read-only versus read-write access, and access to which parts of the record. An existing shared-care-record model (read-only, cross-sector, tested over two years in a regional pilot) was cited as evidence this is deliverable at scale.

Peer support and workforce pipeline. The lack of a peer-support structure and protected learning time for newer independent prescribers, and the pressure this places on junior colleagues and on Designated Prescribing Practitioner (DPP) capacity, were felt to be under-represented in the current findings and worth strengthening in future research.

Gaps flagged mainly through the anonymous poll. A number of points surfaced more through written poll responses than in open discussion. Some are genuine gaps in the survey itself: it did not address de-prescribing, ongoing prescribing data collection or audit-trail practices, or the risk of de-skilling for prescribers who use their qualification infrequently. Others are, in fact, already covered in the full Insights Report but were not visible in the presentation or summary materials on the day, for example, structured CPD and protected learning time are addressed in detail in the report's findings on clinical competence.
Beyond these, attendees also raised a concern that, without sustained NHS investment, prescribers may take their skills into private practice instead, meaning the NHS risks losing the benefit of the very capability it is helping to create, a concern the Insights Report also explores at length, though it was not part of the presentation on the day. There was also a clear request for a sustained public awareness campaign explaining what a pharmacy can and cannot do.

5. Discussion following the Framework presentation

The Framework groups the conditions needed for safe, sustained IP expansion into three interdependent spheres, with a shared vision and the patient at the centre. Feedback is summarised by sphere below, followed by cross-cutting themes.

Structural conditions

- Confirmed as the most visible and most discussed set of conditions: funding, IT interoperability, workforce/skill mix, and physical space (e.g. sufficient consultation rooms) in a busy pharmacy.
- Temporary pharmacy closures, driven by workforce shortages, were raised as a structural risk to patient confidence that should be explicitly captured here.
- Interoperability was framed as the priority IT question: can the patient access their information, can the professional access it, and is it adequate for continuity of care across multiple visits.
- A specific and previously under-recognised gap was raised around implementation support: who actually helps a local site put these structural conditions in place. Local Pharmaceutical Committees (LPCs) were named as a natural home for this, though attendees noted current resourcing pressure on that part of the system.

Relational conditions

- Centres on whether prescribing is genuinely embedded in shared ways of working, or still dependent on local goodwill and individual relationships.
- GP–pharmacy trust was described as the single most important relationship to get right, particularly in an IP pharmacist's first year, and depends on clarity about what each profession expects of the other.
- Attendees were clear that independent prescribing is intended to complement, not replace, general practice. Discussion focused on how assessment, diagnosis, prescribing and referral responsibilities could be coordinated across an integrated pathway between pharmacists, GPs and other primary care professionals, rather than treated as separate or competing services.
- A repeated call to shift the framing from competition to collaboration between professions and between national bodies, with networks, communities of practice and champions to help this happen. GPs already have deaneries for shared learning, but independent prescribers currently do not have an equivalent, and existing NHS England-funded 'teach and treat' centres were cited as a model worth building on.

Confidence conditions

- Described as the least visible but most foundational sphere supporting the structural and relational conditions.
- A significant minority of other professionals in the survey were sceptical of pharmacist clinical competence. In the room, this was described less as scepticism about pharmacists' prescribing knowledge itself, and more specifically as a question of confidence in pharmacists' scope of practice and their assessment and diagnosis of patients. Several attendees distinguished clearly between trusting a pharmacist's knowledge of medicines and trusting their ability to assess and diagnose a patient in the first place. Attendees suggested this distinction is worth exploring further, and in more depth, with GPs and other professional groups, rather than treated as a single, general confidence question.
- Supervision and clinical governance were seen as less of a concern than sustained, ongoing professional support through a prescriber's career.

6. Cross-cutting themes and requested refinements

Make the patient voice structural, not assumed. The single most consistent piece of feedback: the patient should not simply sit at the centre of the diagram by default, but be reflected explicitly within all three spheres, with a defined, ongoing mechanism for feeding patient experience back into the Framework as it evolves (rather than treating it as a one-off validation exercise). Attendees also asked that patients be involved directly in designing that feedback loop, not just consulted on its output.

Add an explicit outcomes layer. The clearest structural suggestion was to add a fourth element - an 'outcomes' ring wrapping around the existing three spheres - so the Framework visibly answers what the benefit is and how success will be measured and evidenced. Within this, attendees discussed the importance of distinguishing outcomes and benefits for patients (for example, faster access and continuity of care) from those for the wider health system (for example, contribution to 'left shift' and reduced hospital attendances or GP workload), while showing clearly how the two are connected. The case for system-level investment rests on the patient-level benefit being real and demonstrable. Several noted that GPs' equivalent frameworks and deaneries already model this kind of learning and evidence infrastructure.

Show it is already happening. Pathfinder sites and devolved-nation experience were repeatedly offered as proof that individual conditions in the Framework are already being met somewhere in the system. Attendees asked for illustrative case studies to be woven into the next draft to demonstrate deliverability, not just aspiration.

Avoid a checklist or siloed columns. Strong caution against organisations treating the three spheres as a static tick-box exercise or building a stand-alone 'prescribing service' rather than embedding prescribing horizontally into existing pharmacy and primary care services.

Reframe conditions as a maturity matrix. The most fully worked-through suggestion (offered independently in the room and in the poll) was to convert each condition into an outcome statement against which an organisation can assess its own maturity, rather than a binary met/not-met condition, recognising that conditions can be met to varying degrees and do not all need to be met for prescribing to be safe and sustainable in every context. Attendees suggested the Framework should work differently, but consistently, at micro (individual organisation), meso (system/regional) and macro (national) level.

National baseline, local flexibility. Broad agreement that a nationally defined minimum offer is needed to prevent variable access to IP by geography, while leaving room for local delivery models. This echoes the more centralised approaches already taken in Scotland and Wales, where large systems are already standardising a minimum local offer to avoid patients receiving different levels of service either side of an internal boundary. Attendees described three levels at which the Framework needs to connect: Integrated Care Board, Place, and Neighbourhood. There were also requests for explicit alignment with parallel work (an imminent national commissioning framework, the NHS 10 Year Plan, and the neighbourhood health agenda) so the Framework does not sit in isolation. Variation in how this should apply across the four nations, such as UK-wide principles versus nation-specific implementation, was also raised as needing clarification.

7. Additional priorities raised via the anonymous poll

Written poll responses submitted after the Framework presentation echoed the room discussion but also surfaced some additional, more specific priorities for the next iteration, summarised here as they were not otherwise voiced in plenary:

- Explain the 'why' up front: several respondents wanted the Framework to open with a clear statement of purpose and intended outcome, so the conditions that follow do not read as barriers for their own sake.
- Define what quality and impact look like, and how they will be captured, rather than leaving measurement to a later stage.
- Build in clear feedback loops showing how ongoing patient feedback and evaluation will inform changes to strategy and delivery over time.
- Embed IP explicitly in existing local planning conversations, including urgent and emergency care, single points of access, and neighbourhood health planning, rather than treating it as a standalone workstream.

- Establish a primary care provider collaborative to give a more unified voice across primary care bodies and support resourcing for local implementation.
- Reflect the practical realities of career-long training and support, team restructuring, and local fit, including named champions who can carry this forward on the ground.

8. Agreed next steps

- Q to incorporate the feedback above into the next iteration of the Framework, with particular attention to the patient-voice and outcomes-layer gaps identified as the two clearest priorities.
- This summary note to be circulated to the project team for review and finalisation before it is circulated to roundtable attendees, consistent with the Chatham House Rule commitment made on the day. Attendees were also invited to send any further written reflections directly to the project team, including material not raised on the day.
- Q to finalise the Framework, incorporating roundtable feedback, for approval by the NPA in line with the agreed project schedule, before moving into the third project phase: development of a maturity roadmap building on the findings and the finalised Framework.
- NPA and Q to consider how the roundtable outcomes, research papers and final Framework are published together, and how wider dissemination (including to NPA members and the four nations) is best sequenced.

9. Closing reflections

Closing remarks framed the roundtable as a significant and long-awaited moment: the ambition for expanded independent prescribing in community pharmacy has been over twenty years in development, and this session was described as an important kick-off point rather than a conclusion. There was clear consensus that England has an opportunity to learn from the more advanced experience of Scotland and Wales, tempered by recognition that England's scale brings additional challenges - 'we have to be national, and work as quickly as we can, but we need to walk before we can run.' Equally strong consensus held that a purely localised approach will not deliver the scale of change required, reinforcing the request for a clear, nationally owned Framework with defined minimum standards.

The patient representatives closed by thanking the group for bringing genuine patient representation into every part of the discussion, rather than as a token presence, crediting the Chair's facilitation as instrumental in making that happen.

Appendix A: Attendee list

The following individuals attended the roundtable. This list records attendance only; consistent with the Chatham House Rule agreed on the day, no comment or view in this note is attributed to any named individual or organisation.

Name	Role and organisation
Adriana Thursby-Pelham	Event Programme Manager, Q community (event logistics)
Andrew Evans	Chief Pharmaceutical Officer for Wales
Darren Blake	COO, Sutton PCNs
Dr Nick Thayer	Head of Policy, Company Chemists' Association
Dr Steve Taylor	Spokesperson, Doctors' Association UK
Emma Anderson	Clinical Services Director, Evans Pharmacy
Fin McCaul	Chair of Service Development Subcommittee and regional Committee member, Community Pharmacy England
Gareth Jones	Director of External and Corporate Affairs, National Pharmacy Association
George Johnston	Assistant Director – Primary Care, NHS Alliance
Ghulam Haydar	National Senior Policy Lead, NHS England
Henry Gregg	CEO, National Pharmacy Association
Dr Ian Cubbin	Chair, NPA Health Education Foundation
Justine Scanlan	Director of Pharmacy, Royal College of Pharmacy
Dr Lem Ngongalah	Researcher, National Pharmacy Association
Lindsey Fairbrother	CEO, Community Pharmacy Shropshire
Lorna Jacobs	Interim Senior Insight Programme Manager, Thiscovery
Luvjit Kandula	Chair, Greater Manchester Primary Care Provider Board
Mark Burdon	Pharmacist, Burdon Pharmacies
Matt Barclay	CEO, Community Pharmacy Scotland
Michael Lennox	Healthcare Consultant and Pharmacist, National Pharmacy Association
Nick Kaye	Board member, National Pharmacy Association

Name	Role and organisation
Sarah Tilsed	Head of Partnerships and Involvement, Patients Association
Sophie Julian	Researcher, Nuffield Trust
Sukhi Basra (Chair)	Vice Chair, National Pharmacy Association
Tasneem Mueen-Iqbal	Deputy Director – Community Pharmacy Contracts, Policy, and Reform, Primary Care and Community Services, NHS England
Tessa Lewis	Lead for Prescribing and Polypharmacy, Royal College of General Practitioners
Victoria Treadway	Research Associate, Q community
Vineta Jain	Independent Prescribing Manager, National Pharmacy Association
Wasim Baqir	Head of Pharmacy Integration, NHS England
William Pett	Interim Director of Policy and External Affairs, Healthwatch

th'scovery

Appendix B: Framework for independent prescribing in community pharmacy, V1

This is the first version of the framework developed by Q, that was presented at the roundtable for discussion.