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Health Education Foundation

NPA NATIONAL PHARMACY ASSOCIATION

Expanding independent prescribing in community pharmacy: professionals' and patients' views.

Insights Report

26 June 2026

At a glance

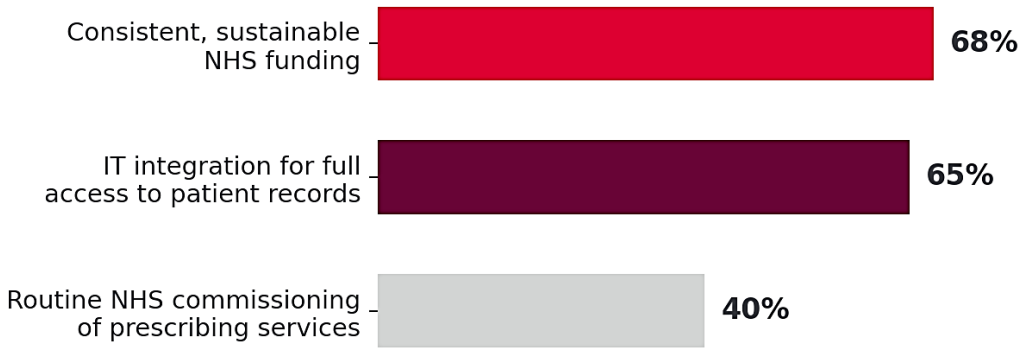
"To better meet patient needs, I believe healthcare services must become more accessible, personalised, and integrated. My vision is for a system that puts patients truly at the centre, where care is not only clinically effective but also compassionate, inclusive, and responsive to individual circumstances."

This report presents findings from three linked surveys exploring independent prescribing in community pharmacy, commissioned by the National Pharmacy Association (NPA) in partnership with Q, and delivered by Thiscovery. Between April and June 2026, **482 participants** shared their views: **187 community pharmacists, 76 other primary care prescribers, commissioners and service planners**, and **219 patients**.

Who took part: 482 people shared their views

Key findings

What pharmacists say matters most for expanding prescribing

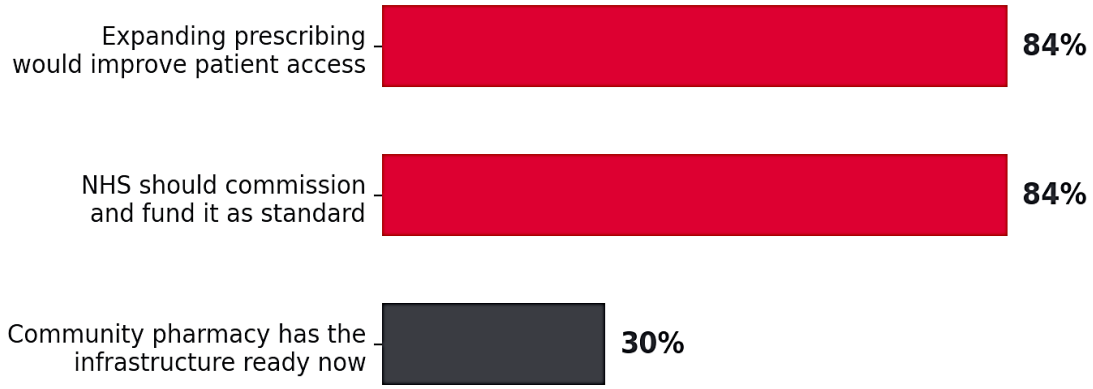


- **Community pharmacists are strongly supportive of expansion but face a system not yet built for it:** 84% (125/149) agreed or strongly agreed that expanding prescribing would improve access to timely treatment for patients, and the same proportion, 84% (125/149), agreed or strongly agreed that the NHS should commission and fund prescribing as a standard part of primary care. Yet only 30% (45/149) felt the current infrastructure was adequate for scale, a gap between aspiration and system readiness that runs through the survey findings as a whole.
- **Prescribing pharmacists operate across both NHS and private services.** Half of the 187 pharmacists surveyed held a prescribing qualification (94/187). Of the 88 who confirmed their prescribing activity, 68% (60/88) were actively prescribing in some capacity (NHS and/or private). Of those actively prescribing, 34% (30/88) were prescribing for both NHS and private patients, 13% (11/88) for NHS patients only, and 22% (19/88) for private patients only. Looking at service type among the 55 actively prescribing pharmacists, 62% (34/55) reported NHS-commissioned services, 27% (15/55) NHS pathfinder or pilot sites, and 78% (43/55) private services, with many active across more than one type simultaneously. Some pharmacists reported shifting away from NHS prescribing towards private-only activity following the end of the IP Pathfinder pilot, which they said increases health inequality and adds to GP workload.
- **A substantial share of qualified pharmacists are not yet prescribing at all.** With 68% reporting that there were actively prescribing, it means **nearly a third of qualified pharmacists responding to this question were not using their qualification to prescribe at all**. This points to a need for expansion to focus not only on training more prescribers, but also on enabling pharmacists who are already qualified to use their skills, through commissioning, clinical pathways and wider support.
- **Funding and IT are the two critical bottlenecks pharmacists identify:** 76% (38/50) of prescribing pharmacists identified appropriate remuneration and funding as needed for improvement; 70% (35/50) cited access to clinical IT systems; sustainable NHS funding was identified as the top priority for expansion (68%, 95/140) with IT integration coming in second (65%, 91/140).
- **The Designated Prescribing Practitioner (DPP) bottleneck is a critical barrier:** Multiple pharmacists described it as extremely difficult to secure a DPP for training placements, with some reporting that they have paid informally (at their own expense) to secure one. Free text analysis also identified this as a frequently mentioned structural barrier to expanding the qualified prescriber workforce, alongside the absence of funded protected learning time.
- **Patients are broadly positive but have clear expectations:** 68% (147/216) already knew pharmacists could prescribe, and 70% (152/216) said they had not yet had a pharmacist prescription but would be happy to try. Comfort was highest for minor acute conditions (88% comfortable for an infected insect bite) and more mixed for higher-complexity scenarios

(55% comfortable for worsening asthma). Patients' top factors for comfort were quick access (56%), privacy (51%), and access to medical history (49%).

- **Other professionals recognise potential benefits but raise concerns about readiness for expansion:** 64% (36/56) of other professionals agreed or strongly agreed that expansion would improve timely access to patient care. At the same time, the majority, 74% (35/47) of clinical prescribers and managers, said community pharmacy does not currently have the workforce and infrastructure needed for scale, and one in four (24%) felt prescribing in community pharmacy added no particular value. Concerns expressed centred on clinical competence and patient safety.
- **There is a striking convergence between pharmacists, other professionals and patients on what safe prescribing requires:** All three groups identified access to medical records, clear escalation pathways, and privacy in consultations as essential, and there is no meaningful disagreement across groups about the common requirements for safe, scaled prescribing. Where views differ is on current readiness for expansion: pharmacists believe the requirements can be met and are ready to move forward; other professionals want more evidence that the necessary systems, infrastructure and safeguards are in place; and patients want reassurance that they already are.

Pharmacists believe in the model, but not that the system is ready



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Introduction

This research was commissioned by the National Pharmacy Association (NPA), in partnership with Q and delivered by Thiscovery, to build a practical, multi-stakeholder evidence base on independent prescribing in community pharmacy. The project had two aims: to capture community pharmacists' first-hand experience of prescribing in practice, and to set that experience alongside the perspectives of other primary care professionals, NHS commissioners, and patients, so that areas of alignment and disagreement between groups could be identified. The findings are intended to inform the development of a national framework for expanding independent prescribing in community pharmacy, developed by Q. The framework will be tested and refined with a group of senior stakeholders at a Deliberative Stakeholder Roundtable before wider publication.

Policy and commissioning context

This research sits within a fast-moving policy environment. The government's 10-Year Health Plan for England (July 2025) sets out a shift toward a 'Neighbourhood Health Service', with community pharmacy moving from a primarily dispensing role towards a more clinical one, including closer integration with patients' shared clinical records. Independent prescribing is central to that shift: from 2026, all newly qualified pharmacists will be independent prescribers on registration, and by August 2025 around a third of all registered pharmacists in Great Britain already held independent prescriber status (General Pharmaceutical Council data).

NHS England's Community Pharmacy Independent Prescribing Pathfinder Programme, which ran from 2024 to late 2025 across close to 200 sites, was established to test models for future commissioning of prescribing services; its evaluation is expected to shape the governance, funding and digital infrastructure needed for prescribing to move from pilot to permanent NHS service. The National Pharmacy Association has argued that the current Community Pharmacy Contractual Framework needs fundamental reform to support this transition and has called for a nationally consistent framework that secures funding and policy support to scale independent prescribing from pathfinders to permanent NHS services.

Current policy momentum, alongside the end of the Pathfinder pilot, creates a time-limited opportunity to secure consistent commissioning arrangements and national support for community pharmacy prescribing. This report presents the survey findings intended to inform that process.

Project team

This project was guided by a multidisciplinary National Pharmacy Association project team bringing together pharmaceutical and research expertise:

- Gareth Jones, Director of External and Corporate Affairs
- Michael Lennox, Strategic Development Specialist
- Dr Lem Ngongalah, Public Health Researcher
- Dr Jill Loader, Adviser
- Vineta Jain, Independent Prescribing Manager

Note on reported numbers

Throughout this report, findings are presented using both percentages and raw numbers to provide full transparency. The format used is X% (n/N), where n is the number of respondents who gave a particular answer and N is the total number who answered that question. For example, '65% (74/113)' means 74 out of 113 respondents who answered this question selected this option.

Response rates vary throughout the report because not all questions were mandatory and some questions were shown only to relevant sub-groups (for example, questions about current prescribing practice were shown only to qualified prescribers). The base for each finding is clearly stated. Percentages throughout are calculated based on the number of people responding to each specific question.

Full data tables are provided in Annex 1. Coding frameworks and participant quotes are provided in Annex 2. Full survey questions are provided in Annex 3.

Who took part?

This report draws on three separate but linked surveys. Two surveys were designed for professionals (one for community pharmacists and one for other healthcare professionals and commissioners) and one for patients.
This report brings together the perspectives of 263 professionals and 219 patients on the expansion of independent prescribing in community pharmacy.

Professional participants

A total of 263 eligible professional participants are included in the analysis. Participants were drawn from four eligible professional groups:

1. **Community pharmacists (187, 71%):** the largest group, spanning those already qualified to prescribe, those in training, those interested in training, and those who do not plan to train.
2. **GPs, nurse prescribers and other primary/urgent care prescribers (61, 23%):** including GPs, GP-practice prescribing pharmacists (who formed the largest sub-group at 38% of this route), advanced clinical practitioners, and nurse prescribers.
3. **Practice, Primary Care Network (PCN), Neighbourhood and Local Area Managers without commissioning responsibilities (3, 1%)**
4. **NHS commissioning, planning and service design roles (12, 5%):** including ICB or Health Board commissioners, and those in national or local NHS planning roles.

For clarity throughout this report, we refer to the second, third and fourth groups collectively as 'other professionals', noting where findings differ between clinical prescribers and commissioners.

Community pharmacist profile

The 187 community pharmacists who took part brought considerable experience. Among those who provided this information (n=140), 89% (124/140) had more than ten years' experience as a qualified pharmacist. The majority worked full or substantial hours, with 42% (59/140) working more than 37.5 hours per week and 29% (40/140) working 30–37.5 hours per week.

Pharmacy setting split broadly between independent and chain pharmacies: 55% (77/140) worked primarily in an independent community pharmacy and 36% (50/140) in a chain or multiple. Most were based in England (87%, 116/133), with 9% (12/133) in Scotland and smaller representation from Wales and Northern Ireland.

The age profile showed most pharmacists were in mid-career: 36% (49/135) aged 45–54, 27% (37/135) aged 35–44, and 26% (35/135) aged 55–64. The sample was 57% (78/138) women and 41% (56/138) men.

You can see a full breakdown of community pharmacists' characteristics in Table 1.

Table 1: Community pharmacists' participant profile

Characteristic	n	%
Total participants	**140**	**100%**
Years experience	**140**	**100%**
Less than 1 year	1	1%
1 to 2 years	3	2%
3 to 5 years	2	1%
6 to 10 years	7	5%
More than 10 years	124	89%
Prefer not to say	3	2%
Years qualified to prescribe	**71**	**100%**
Less than 1 year	12	17%
1 to 2 years	15	21%
3 to 5 years	19	27%
6 to 10 years	11	15%
More than 10 years	14	20%
Prefer not to say	0	0%
Type of pharmacy	**140**	**100%**
Community pharmacy (chain / multiple)	50	36%
Community pharmacy (independent)	77	55%
GP practice-based pharmacy	5	4%
Urgent care / walk-in centre	0	0%
Hospital outpatient pharmacy	0	0%
Other	5	4%
Prefer not to say	3	2%
Country	**133**	**100%**
England	116	87%
Northern Ireland	1	1%
Scotland	12	9%
Wales	3	2%
Prefer not to say	1	1%
Hours worked a week	**140**	**100%**
Less than 15 hours	7	5%
15 to 22.5 hours	13	9%
22.5 to 30 hours	17	12%
30 to 37.5 hours	40	29%
More than 37.5 hours	59	42%
Prefer not to say	4	3%
Age	**135**	**100%**
Under 25	0	0%
25 – 34	6	4%
35 – 44	37	27%
45 – 54	49	36%

Characteristic	n	%
55 – 64	35	26%
Over 65	8	6%
Gender	**138**	**100%**
Woman	78	57%
Man	56	41%
Non-binary	0	0%
My gender is not listed	0	0%
Prefer not to answer	4	3%

Other professionals' profile

Among the 42 participants in clinical prescriber and manager roles who provided role information, the largest single group was GP-practice prescribing pharmacists at 38% (16/42), followed by GPs at 36% (15/42). The 9 commissioners were predominantly ICB or Health Board commissioners (44%, 4/9) or those in other national or local NHS planning roles.

Most other professionals had extensive experience: 29% (15/51) had been in their current role for more than ten years, and 24% (12/51) for six to ten years. The majority, 51% (26/51), worked primarily in a GP practice. Most were based in England (92%, 46/50).

For a full breakdown of other professionals' characteristics, see Table 2.

Table 2: Other professionals' participant profile

Characteristic	n	%
Total participants	**51**	**100%**
Role (commissioners)	**9**	**100%**
ICB or Health Board commissioner / manager	4	44%
Other NHS planning or commissioning role - local	1	11%
Other NHS planning or commissioning role - national	2	22%
Other	2	22%
Prefer not to say	0	0%
Role (general practice)	**42**	**100%**
GP / GP Partner	15	36%
Practice manager	0	0%
PCN, Neighbourhood or Local Area lead or manager	1	2%
Nurse prescriber (practice nurse, community nurse, etc.)	2	5%
GP Practice prescribing pharmacist	16	38%
Advanced clinical practitioner	4	10%
Urgent care service manager / clinician	0	0%
Other	3	7%
Prefer not to say	1	2%
Years in current role	**51**	**100%**
Less than 1 year	3	6%
1 to 2 years	4	8%

Characteristic	n	%
3 to 5 years	17	33%
6 to 10 years	12	24%
More than 10 years	15	29%
Prefer not to say	0	0%
Setting	**51**	**100%**
GP practice	26	51%
Primary Care Network, Neighbourhood or Local Area	4	8%
Community / district nursing	0	0%
Urgent care / walk-in centre	1	2%
Integrated Care Board / Health Board commissioning office	6	12%
Hospital (outpatient / discharge services)	1	2%
Community pharmacy	3	6%
I work across multiple settings	8	16%
Other	1	2%
Prefer not to say	1	2%
Country	**50**	**100%**
England	46	92%
Northern Ireland	0	0%
Scotland	1	2%
Wales	2	4%
Prefer not to say	1	2%
Population served	**51**	**100%**
Under 50,000	24	47%
50,000 to 100,000	10	20%
100,000 to 250,000	5	10%
250,000 to 500,000	1	2%
500,000 to 1 million	2	4%
Over 1 million	8	16%
Don't know / not applicable	1	2%
Age	**47**	**100%**
Under 25	0	0%
25 – 34	7	15%
35 – 44	10	21%
45 – 54	19	40%
55 – 64	9	19%
Over 65	2	4%
Gender	**48**	**100%**
Woman	28	58%
Man	18	38%
Non-binary	0	0%
My gender is not listed	1	2%
Prefer not to answer	1	2%

Patient participants

A total of **219 eligible patients** took part in the patients' survey. To be eligible, participants needed to be 18 or over and have used a pharmacy for any reason. They did not need to have had a prescription written by a pharmacist.

The age profile was notably older, with **51% (102/199) aged over 65 and 19% (37/199) aged 55–64**. Those under 35 represented only 8% (14/199) of the sample.

The sample was 66% (136/206) women and 32% (65/206) men, predominantly White (85%, 176/207). The largest regional group was from the East of England (37%, 77/208), with London (9%, 19/208), the South East (10%, 20/208) and the Midlands (12%, 24/208) also well represented.

You can see a full breakdown of patients' characteristics in Table 3.

Table 3: Patients' participant profile

Characteristic	n	%
Total participants	**208**	**100%**
Age	**199**	**100%**
Under 25	1	1%
25 – 34	13	7%
35 – 44	22	11%
45 – 54	24	12%
55 – 64	37	19%
Over 65	102	51%
Ethnic group	**207**	**100%**
Asian or Asian British	12	6%
Black, Black British, Caribbean or African	5	2%
Mixed or Multiple ethnic groups	3	1%
White	176	85%
Other ethnic group	3	1%
Prefer not to say	8	4%
Gender	**206**	**100%**
Woman	136	66%
Man	65	32%
Non-binary	2	1%
My gender is not listed	0	0%
Prefer not to answer	3	1%
Region	**208**	**100%**
East of England	77	37%
London	19	9%
Midlands	24	12%
North East and Yorkshire	16	8%

Characteristic	n	%
North West	23	11%
Northern Ireland	1	<1%
Scotland	4	2%
South East	20	10%
South West	18	9%
Wales	4	2%
Prefer not to say	2	1%

Understanding the sample

All three surveys used purposive sampling, with participants invited through multiple channels. Professionals were invited primarily through NPA, Q and other partner networks; patients were invited through patient representative groups with which NPA had established relationships. Thiscovery also recruited to all three groups through its own participant crowd and networks. This means findings cannot be treated as statistically representative of all community pharmacists, all other healthcare professionals, or all patients in the UK. They represent the views of those who chose to engage, and are particularly skewed towards experienced pharmacists, GP-based professionals, older patients, and those broadly comfortable with digital engagement. Experiences of early-career pharmacists, those working in non-pharmacy settings, younger patients, and those from minority ethnic communities are less fully represented. These characteristics should be borne in mind throughout.

In addition, while recruitment was UK-wide, the great majority of responses came from England, and the devolved nations differ in their policy, commissioning and infrastructure context for independent prescribing. Conclusions and recommendations should not be assumed to transfer directly to Scotland, Wales or Northern Ireland without local consideration.

How did we hear from them?

Community pharmacists, other healthcare professionals and patients were invited to complete their relevant survey on the secure, independent Thiscovery platform (thiscovery.org) between 22 April to 7 June 2026. The research was led by the National Pharmacy Association (NPA) in partnership with Q and facilitated by Thiscovery.

What questions were asked?

The surveys used a combination of closed-ended questions with open-ended free-text questions. Community pharmacists and other professionals entered the survey via the same project page, and the survey was then split into two separate questionnaire routes according to their role selection at the start. The patients had a separate project page and survey. All three surveys covered related topics, enabling comparison of perspectives across groups.

Community pharmacists were asked about:

- Current prescribing qualification and practice
- The differences between NHS and private prescribing
- Barriers and enablers to prescribing
- What supports competence development and maintenance
- Views on collaboration with GPs and other healthcare colleagues
- Perceptions of the value of independent prescribing
- Views on expansion of independent prescribing

Other professionals were asked about:

- How frequently they encounter community pharmacy prescribing
- The commissioning landscape in their area
- How well different prescribers work together
- Views on integration challenges
- Perceptions of the value of independent prescribing
- Views on expansion of independent prescribing

Patients were asked about:

- Awareness of pharmacist prescribing
- Experience of receiving a pharmacist prescription
- Comfort with prescribing across five clinical scenarios
- What matters most to patients for pharmacist prescribing
- Concerns about community pharmacy prescribing
- The factors influencing their willingness to use the service.

All participants were also asked demographic questions relevant to their background.

You can see the full survey questions in Annex 3 to this report.

Community pharmacists

Prescribing in practice, who is prescribing, what, and where

Understanding who is currently prescribing, what they prescribe, and under what conditions is essential context for interpreting pharmacists' views on expansion. This section describes the prescribing landscape among the 187 community pharmacists who participated.

Qualification status: half are qualified, most of the rest want to be

Of the 187 pharmacists who took part, **50% (94/187) were currently qualified as independent prescribers**. Among those who were not yet qualified, **27% (50/187) expressed an interest in training but had not yet started**, and 7% (13/187) were already in training. Only 16% (30/187) said they were not qualified and did not plan to train. The profile of the sample therefore skews considerably towards pharmacists who are either already prescribing or intending to.

Who is actively using their qualification, and who isn't: nearly a third are not

Among the 94 qualified prescribers, 88 answered questions about current use. Of these, **32% (28/88) were not currently using their prescribing qualification to prescribe**. Of those actively prescribing, 34% (30/88) were prescribing for both NHS and private patients, 13% (11/88) for NHS patients only, and 22% (19/88) for private patients only. This presents a mixed picture, with 68% (41/60) of those prescribing having some NHS prescribing activity.

The picture of those **not using their qualification** is striking. When asked about structural and commissioning barriers, **88% (23/26) said NHS prescribing services are not commissioned in their area**, and 81% (21/26) said there are no local clinical pathways integrating community pharmacy prescribing into primary care. Practice-level barriers were also significant: 36% (9/25) cited time constraints, 36% (9/25) cited insurance or legal concerns, and 32% (8/25) said they lacked confidence or that GPs or other health professionals did not support pharmacist prescribing.

> *"I prescribe as part of my role as a GP pharmacist; where I work most of my hours now. Private prescribing occasionally only. I wouldn't prescribe in the community pharmacy, lack of proper insurance, lack of proper appointments, lack of support and lack of renumeration."*

What prescribers prescribe for, and how often

Among the 55 pharmacists who were actively prescribing and answered questions about their practice: **58% (32/55) prescribed daily or on most days**, and a further 15% (8/55) prescribed weekly. A third (33%, 18/55) spent more than 16 hours a week on prescribing activity; 36% (20/55) spent less than 4

hours. Most prescribed in a single community pharmacy site (69%, 38/55), though 24% (13/55) worked across two or three sites.

The most commonly prescribed conditions were minor ailments and acute self-limiting conditions (76%, 42/55), ear, nose and throat conditions (69%, 38/55), UTIs (65%, 36/55), and dermatological conditions (64%, 35/55). Weight management (51%, 28/55) and allergic conditions (51%, 28/55) were also frequently prescribed for; the relatively high weight management figure reflects the private sector focus of many prescribing pharmacists.

How practice has evolved since qualification

For most qualified prescribers who answered this question, practice has broadened significantly. **80% (43/54) said their prescribing practice had changed since first qualifying**, and of these, 90% (36/40) said they were now prescribing for more conditions and 53% (21/40) had increased their prescribing hours.

NHS and private prescribing: a mixed picture with a growing private sector

The breakdown of service type presents a mixed picture. Because participants could select multiple options, many prescribing pharmacists were active across both NHS and private settings simultaneously. Of the 55 actively prescribing pharmacists, **62% (34/55) were prescribing in NHS-commissioned services, 27% (15/55) in NHS pathfinder or pilot sites, and 78% (43/55) in private services**. Combining the two NHS categories, the majority of active prescribers had some NHS prescribing activity. This is consistent with the numbers on how qualified prescribers are using their qualification, which shows 68% (41/60) prescribing for NHS patients either exclusively or alongside private work. However, free text responses pointed to a real and concerning dynamic: where the IP Pathfinder programme has ended without a successor commissioning model, some pharmacists have shifted from NHS to private-only prescribing, or stopped prescribing altogether. Some who remain in NHS services describe this shift as worsening health inequality and adding back to GP workload.

> *"NHS prescribing was done via the IP Pathfinder Pilot. This includes mostly minor ailments and some ailments outside the scope of the PGDs... As the pilot has now ended, a lot of these prescribing interactions are now being conducted privately or being referred back to GPs if cost is an issue, increasing workload on the GPs and increasing health inequalities."*

A number of pharmacists described prescribing privately for: weight management (10 mentions), patients who are not eligible for NHS prescriptions such as tourists (7 mentions), travel vaccines and medication (4 mentions), and conditions not routinely covered by the NHS such as adult ear

infections or some skin conditions (4 mentions). The sharp contrast between what NHS commissioning covers and what patient need exists was a recurring theme, with pharmacists positioned in an uncomfortable middle, able to meet the need privately but not systemically.

> *"Private Weight management, no commissioned service. Private Travel and vaccines, no commissioned service. Often people will choose this because schools vaccination service is difficult to use or they cannot get into their GP."*

Patient Group Directions (PGDs): a parallel system that complicates the picture

A significant proportion of pharmacists used Patient Group Directions (PGDs) alongside or instead of full independent prescribing. Among those currently using their prescribing qualification (n=53), **49% (26/53) used PGDs for both NHS and private services and 36% (19/53) for NHS services only**. Among those not currently using their qualification (n=26), 65% (17/26) were using PGDs for both NHS and private services. PGDs thus represent an important middle ground, allowing medicine supply without the full independent prescribing process, but are not considered equivalent by most pharmacists in the sample, who valued the clinical depth and individualisation that independent prescribing enables.

Challenges and what would help, prescribing pharmacists

For pharmacists who were qualified and actively prescribing, the survey explored what was making prescribing difficult and what was most needed to improve practice. These findings reflect the reality of day-to-day prescribing in community pharmacy.

Funding and remuneration: a critical barrier to improving prescribing practice

Among the 50 active prescribers who answered questions about challenges, **66% (33/50) identified limited commissioning or funding for pharmacist prescribing services as a barrier**. When asked what improvements were most needed, appropriate remuneration and a sustainable funding model was the most frequently selected option (76%, 38/50).

The message from free text responses was equally direct: without financial viability, scaling prescribing is impossible, especially for smaller independent pharmacies.

> *"Community pharmacy is fundamentally underfunded and dispensing happens at a loss increasingly more often, without addressing funding to ensure additional tasks and responsibilities associated with prescribing are covered and that there is a net financial benefit to offering prescribing at community pharmacy level, there will always be reluctance to introducing this at scale across the country. Larger chains will find ways of absorbing cost... whereas smaller pharmacies will simply face impossible demands."*

The absence of a financial benefit for holding an independent prescribing (IP) qualification was raised repeatedly. As one participant put it:

> *"And honestly there has to be a financial benefit to having an IP qualification. If IP pharmacists can't get better wages then many will not bother learning it."*

IT systems and clinical records: equally critical

Access to clinical IT systems was the second most commonly identified improvement need, selected by **70% (35/50) of active prescribers**. Separately, 48% (24/50) reported that limited access to relevant clinical records was a current barrier to prescribing. Free text responses throughout the survey consistently described the absence of integrated records access as both a safety concern and a practical impediment.

> *"1) we need access to all prior and relevant stuff before prescribing anything including but not limited to liver tests, renal tests, electrolytes, inflammatory markers, blood counts, cardiac markers. 2) we need*

allocated appointment times just like doctors do so we are not rushed. 3) we need someone to check our work. Doctors have a safety net of pharmacists, but who safety nets us?"

This question of clinical safety infrastructure, including who checks a prescriber's work in a community setting, was a recurring theme, and one that other professionals also raised (see Section 8). The absence of a 'safety net' for prescribing pharmacists was described by pharmacists themselves, not only by other professionals.

Integration into care pathways

Better integration of pharmacist prescribing into local care pathways was selected by **66% (33/50)**, alongside NHS commissioned prescribing services (64%, 32/50) and better integration with GP practices and wider primary care teams (64%, 32/50). Clear local referral and escalation pathways were needed by 50% (25/50), and access to the electronic prescription service by 46% (23/50).

Referral systems, in particular, were described as both central to patient safety and often dysfunctional. Pharmacists wanted clearer routes, both to receive patients from GPs and to refer patients back. The recurring description of working without a clear clinical network left many feeling professionally isolated.

"*Access to patient records and system integration so any interventions can be added to the patient records. Community Pharmacists be part of local GP MDT meetings and have a healthy working relationship with GPs. GP surgery staff be more supportive to the prescribing in Community Pharmacy.*"

Patient awareness: understanding scope, not just existence

Notably, **36% (28/50) of active prescribers cited low patient awareness or demand as a barrier** to prescribing. This connects to two distinct issues in the patient data. Most patients were already aware that pharmacists can prescribe at all (68%, 147/216), so awareness of the service's existence is not, on its own, the main gap. The more significant gap is in understanding what pharmacists can prescribe for, when it is an appropriate choice, and how to access it: 32% (69/216) of patients were still uncertain or unaware even at this basic level. Pharmacists were clear that a national campaign would help, though this points to a campaign framed around building understanding of the scope and appropriate use of the service, rather than simply raising awareness that it exists.

"*Increase patient awareness of services available so [patients] utilise [the] service more frequently for appropriate reasons.*"

The DPP bottleneck: a crisis for the training pipeline

Among the 26 pharmacists who were qualified but not prescribing, when asked about practice-level barriers, a picture emerged of structural underfunding of the very pipeline meant to increase prescriber numbers. Confidence (32%, 8/25) and lack of GP or professional support (32%, 8/25) were identified, but across the full free text dataset, the **DPP (Designated Prescribing Practitioner) shortage** was the theme described in the most urgent terms, as a critical barrier to completing training regardless of motivation, as the quotes below illustrate.

> *"To make routine NHS commissioning a reality, we have to bridge the massive gap between theoretical qualification and actual clinical confidence on the ground... The biggest difference will come from fixing the critical bottleneck around Designated Prescribing Practitioners (DPPs) and clinical mentoring. Thousands of experienced UK community pharmacists want to step up, but they are completely locked out of programs because they cannot secure a DPP or a supervised practice placement."*

> *"Having local or national funding to pay for DPP, often the Pharmacist has to pay an underhanded payment to their DPP to be their DPP. There is no official contract in place and training could be withdrawn at any time by DPP."*

The lack of central coordination and often unfunded nature of DPP arrangements, with pharmacists sometimes paying informally to secure supervisors, and with no formal contract protecting either party, was described as undermining both the quality and the equity of training. Several respondents noted that pharmacists outside major cities, or in smaller independent pharmacies, were particularly disadvantaged.

Clinical competence, development and collaboration

This section covers how pharmacists, both qualified prescribers and those working towards or considering a qualification, think about their clinical competence, what would help develop it, and how they experience working with GP and PCN colleagues.

What helps pharmacists develop and maintain competence

Pharmacists with a prescribing qualification (whether currently using it or not) were asked what would help them develop or maintain clinical competence (n=89). Structured learning about specific conditions was the most commonly selected option, chosen by **83% (74/89)**. Clear escalation pathways were needed by 64% (57/89) and keeping up to date with new medicines and clinical evidence was selected by 60% (53/89). Support with managing complex or multi-morbid patients was also identified by 60% (53/89), alongside peer learning from other prescribers and access to formal clinical supervision from a senior prescriber or GP, each at 58% (52/89).

Table 4: What would help to develop or maintain clinical competence to prescribe (n=89, multiple selection)

Support need for competence	n	%
Structured learning about specific clinical conditions	74	83%
Clear escalation pathways	57	64%
Keeping up to date with new medicines, guidelines and clinical evidence	53	60%
Support with managing complex or multi-morbid patients	53	60%
Peer learning from / shadowing other prescribers	52	58%
Access to formal clinical supervision from a senior prescriber or GP	52	58%
Regular, ongoing clinical supervision built into my role	46	52%
Guidance on when and how to refer patients to GPs or other clinicians	51	57%
Formal training in consultation skills and medicines decision-making	41	46%
A structured portfolio or revalidation framework for prescribers	35	39%

The pattern is notable. Pharmacists are not asking simply for more training, they are asking for the kind of ongoing, embedded, relational support (supervision, peer learning, escalation pathways, mentoring) that characterises professional development in medicine and nursing, but which

has rarely been systematically provided in pharmacy. Free text responses reinforced this: the desire was not for a single qualification but for a career-long framework of clinical development.

> *"1) Money has to be right to fund continued development of prescriber and his/her infrastructure 2) Protected learning time needs to be baked in so support staff, employers and colleagues understand and support 3) Inter-disciplinary meetings amongst everyone prescribing for a population at say 6-monthly intervals are essential. More is achievable in coffee breaks and in the car park than on a zoom meeting."*

Support from general practice colleagues: mixed and patchy

Community pharmacists were asked how supportive general practice colleagues (GPs and nurses) in their area had been towards prescribing in community pharmacy (n=157). **35% (55/157) described colleagues as very or quite supportive**. But 25% (39/157) said GP colleagues were neutral, 10% (16/157) were somewhat unsupportive, and 5% (8/157) were very unsupportive, opposed to it. A further 25% (39/157) said they simply didn't know or had no contact with general practice colleagues.

Support from pharmacists already working in general practice, PCNs, Neighbourhoods and Local Areas was somewhat more positive: **43% (67/155) described these colleagues as very or quite supportive**, with 25% (39/155) neutral and a further 10% (15/155) describing them as somewhat or very unsupportive. However, 22% (34/155) had no contact with these colleagues either, reflecting how siloed community pharmacy remains from wider primary care structures.

Free text responses added important nuance to these figures. Support was often personal, relational, and local rather than structural:

> *"GP–Pharmacist relationship, sort that and the rest will follow. It's personal relationships that get things done."*

> *"Community pharmacists mostly understand GP practice, many have worked in the setting in roles, during training etc. But [it is] rare for staff from GP practice to spend time in community pharmacy. Wouldn't harm to introduce a primary care 'walking in each other's shoes' event."*

Respondents also described a dynamic where the goodwill of individual GPs was undercut by system-level tensions, particularly around funding, where prescribing budgets and commissioning arrangements were seen as placing GP and community pharmacy (CP) interests in competition rather than alignment.

"This 'collaboration' cannot take place because of the goodwill at grassroots which evaporates higher up the chain we proceed. The GP and CP national contracts need to mandate inter-professional cooperation to benefit patients."

What would improve collaboration: practical proposals from pharmacists

Pharmacists were asked what would improve collaboration with GPs and other NHS staff (n=87 who provided a free text response). The coded analysis identified several consistent themes: building understanding and trust of each other's roles through joint training, shadowing and meetings (21 mentions); improving integration of patient data IT systems (13 mentions); better referral systems (10 mentions); improved communication generally (12 mentions); and addressing the budget and contract arrangements that drive competition rather than collaboration (7 mentions for current budget systems being prohibitive, 6 for needing to align national pharmacy and GP contracts).

"Better understanding of each other's roles. Cross sector shadowing to understand the requirements. Alignment of the contract to work together rather than be seen in competition with each other."

"I would like to see hybrid roles for both pharmacists and technicians, where funding was allocated for roles that MUST be spread 50:50 between GP practices/PCNs and community pharmacies instead of allowing GPs to use the ARRS funding to employ their own pharmacy teams. This would see opportunities for greater understanding of each other's sector, greater collaboration, greater access to patient notes... and a much smoother patient journey."

Views on value and expansion

This section presents pharmacists' views on where prescribing currently adds value, their level of agreement with statements about expansion, their priorities for what matters most, and their visions for what routine NHS-commissioned prescribing would look like.

Where prescribers see value now

Pharmacists (n=150) were asked to identify up to three areas where prescribing currently adds the most value. **Managing minor acute illnesses (72%, 108/150) and accessible locations for patients (59%, 88/150)** were by far the most commonly selected. Convenient appointments for patients followed at 39% (58/150). Medicines expertise and safety was chosen by 32% (48/150) and reducing GP or nurses' workload by 24% (36/150).

Notably, just 1% of pharmacists (2/150) selected 'I don't think it adds any particular value'.

Strong support for expansion, tempered by infrastructure realism

Pharmacists' agreement with statements about expansion revealed a clear pattern of high optimism about the principle, combined with a contrasting realism about current infrastructure.

Table 5: Pharmacists' agreement with statements about expansion

Statement	Mean score (/5)	% Agree or strongly agree
Expanding prescribing would improve access to timely treatment	4.34	84% (125/149)
The NHS should commission and fund it as standard primary care	4.35	84% (125/149)
I/pharmacists could take on more prescribing if support were in place (qualified prescribers)	4.49	86% (63/73)
I/pharmacists could take on more prescribing if support were in place (non-qualified)	3.97	74% (55/75)
Community pharmacy has the workforce and infrastructure needed for scale now	2.74	30% (45/149)

The gap between mean scores of 4.34–4.49 for aspiration-based statements and just 2.74 for infrastructure readiness is the defining feature of pharmacists' outlook. **They believe in the model. They do not believe the system is currently built for it.** This is not pessimism but a specific, practical diagnosis: fund it, build IT access, create pathways, and capacity will follow.

"Funding. If there is funding available to pharmacies for partaking in prescribing services, everything else will follow. This will enable more pharmacies to utilise skills they already have and change the way of working."

What matters most for expanding prescribing

Pharmacists (n=140) were asked to select up to three priorities for expansion. The top priorities were:

- **Consistent and sustainable NHS funding:** 68% (95/140)
- **IT integration for full access to patient records:** 65% (91/140)
- **Routine NHS commissioning of prescribing services:** 40% (56/140)
- **Pharmacist competence and confidence with clinical supervision and escalation pathways:** 37% (52/140)
- **Clearer clinical pathways embedding community pharmacy in primary care:** 29% (40/140)

Funding and IT integration emerged as the two clear top priorities, selected by 68% and 65% of pharmacists respectively, reflecting pharmacists' understanding that these are structural prerequisites for safe, scalable prescribing.

What would make NHS-commissioned prescribing a reality

In response to the open question about actions that would make the biggest difference, pharmacists produced a rich and detailed analysis. Coded responses from the 72 pharmacists who engaged with this question identified the following major themes: adequate funding for prescribing services and roles (28 mentions); IT integration (13 mentions); pharmacist access to patient records including test results and monitoring data (9 mentions); improving access to clinical supervision and mentorship (10 mentions); GP–pharmacist relationships (10 mentions); and national governance/policy frameworks (9 mentions for clinical governance policies and frameworks).

"The biggest difference would come from aligning policy, funding, clinical governance, and operational systems so prescribing becomes a normal commissioned service, not an exceptional pilot. A nationally specified prescribing framework from NHS England. Clear service specifications. Standardised inclusion criteria. Defined outcome measures. Long-term commissioning rather than short pilots."

"Community pharmacy needs to firmly be placed within the Primary Care teams, funded appropriately and given a greater voice and influence. We see most patients significantly more than GPs and are brilliantly placed to have a great, and proven economically viable, impact on patient care and the patient journey."

A minority of pharmacists raised concerns about the pace of expansion, specifically around governance and safety, echoing the 9 mentions separately calling for national governance and policy frameworks when asked what would make the biggest difference:

> *"We need a robust, multi-year mentoring framework that lets us practice under direct clinical supervision before being left isolated. If the regulator and commissioners flood the system with prescribers without building a bulletproof clinical governance structure, it will lead to cognitive exhaustion, diagnostic errors, and a surge in defensive practice that backlogs secondary care."*

This is not an isolated view: alongside the calls for national governance and policy frameworks noted above, it demonstrates that pharmacists' enthusiasm for the model is accompanied by genuine professional responsibility and an understanding of the complexity of scaling safely.

Other prescribing professionals and commissioners

Encountering and commissioning community pharmacy prescribing

Understanding how other professionals encounter community pharmacy prescribing in their daily work, and the commissioning landscape they operate within, is essential context for interpreting their views on value and expansion.

Frequency of encounter: a divided group

The 64 other professionals who answered the question about how often they encounter community pharmacy prescribing in their practice showed a bimodal pattern. **52% (33/64) encountered it daily or weekly**, while 30% (19/64) encountered it rarely and 14% (9/64) had never encountered it. The 5% (3/64) who encountered it monthly represent a smaller middle group.

This polarisation reflects the uneven landscape of IP commissioning across the UK, some areas have active and integrated services, others have virtually none. Those who encounter it regularly are likely to be in areas with active pathfinder or pilot activity, or in roles (such as GP-based prescribing pharmacists) where they directly encounter community pharmacy services as part of their work.

Free text responses from those encountering it regularly revealed the range of contexts: patients accessing community pharmacy for advice and minor ailments (10 mentions); prescribing pharmacists being integrated into practice teams (8 mentions); seeing patients who had previously been seen at pharmacy (6 mentions); and directing patients towards pharmacy services (4 mentions). But also, and this is significant, seeing patients whom pharmacy had been unable to help (3 mentions), and reviewing prescriptions issued by community pharmacists (6 mentions), sometimes with concerns:

> *"Patients come to me after treatment failure. Often misdiagnosis. Giving antibiotics and patients report no thorough history or examination. Where is the antibiotic stewardship that we are held to as GPs?"*

This quote, from a GP, is one of several in the data that illustrate how a minority of poor prescribing experiences can disproportionately shape the views of other professionals. It does not represent the majority view, but it is a significant signal about the importance of clinical governance in building professional trust.

The commissioning landscape: patchy and mainly in early stages

Because the commissioner sub-group is small (n=9–12 depending on the question), the findings below should be read as illustrative of a pattern rather than statistically definitive. Even so, the commissioning picture across the sample reflected the UK's fragmented, non-standardised approach to community pharmacy prescribing.

Among the 57 clinical prescribers and managers, **37% (21/57) said prescribing was commissioned in their area, 26% (15/57) said it was not, and a striking 37% (21/57) said they didn't know**. The high proportion who don't know, nearly as many as those who say it is commissioned, reflects how poorly integrated community pharmacy is into the awareness of other primary care professionals, even in areas where services exist.

Among the 9 commissioners who answered the commissioning level question, **78% (7/9) said prescribing should be commissioned at both local and national levels**, with 22% (2/9) favouring national commissioning only. This strong preference for a hybrid approach aligns with what pharmacists described: the need for national frameworks with local flexibility.

Where commissioning exists: the IP Pathfinder legacy

Among the commissioners, **75% (9/12) reported that they or their ICB/Health Board had been part of the IP Pathfinder pilot**. Of these, 43% (3/7 who answered) had continued the programme, 29% (2/7) had not, and 29% (2/7) didn't know. The two free text responses from those who had continued described continued investment to preserve the governance and workforce capabilities developed during the pilot, and illustrated the kind of genuinely integrated, data-connected service that was possible when conditions were right:

> *"Our IP Pathfinder Programme was unique in that: close collaborative working with GP Federation, PCN and GP Practices; The pharmacies have full access to the EMIS clinical system and patient records; Pharmacists are able to issue FP10 through EMIS; Pharmacies can order blood tests through EMIS. Patient feedback has been very good for the service. Initial evaluation from 70 patients showed an average decrease of 10mmHg systolic."*

The description of commissioning services across areas that had active services included: IP Pathfinder continuation services (5 mentions); NHS pharmacy contraception service (3 mentions); Pharmacy First (2 mentions); common ailments including sore throat, UTI and ear infection (2 mentions); and specific clinical services including lipid management, DOACs initiation, and hypertension management (1 mention each). Scotland was noted as having a nationally commissioned service.

Barriers to commissioning: funding and IT dominate

Among the small number of commissioners who had not commissioned prescribing and answered questions about barriers (n=5), **100% (5/5) cited insufficient funding/budget and 100% (5/5) cited IT/systems integration challenges** as barriers. Unclear pathways or governance were identified by 80% (4/5), concerns about quality or safety by 60% (3/5), and GP resistance or concerns by 40% (2/5). The uniformity of funding and IT as barriers across both pharmacists and commissioners is one of the most consistent findings across the entire dataset.

System integration, how well do services work together?

This section presents other professionals' and commissioners' views on how well different prescribers currently work together, what the biggest integration challenges are, and what might help overcome them.

Current state: working separately is the dominant picture

Of the 60 other professionals who answered the question about how well different types of prescribers work together in their area, **42% (25/60) said different prescribers work separately in their own areas**, the single most common response. A further 13% (8/60) said there were tensions between different prescriber groups. Only 8% (5/60) said they had strong multi-disciplinary prescribing teams working well together, while 30% (18/60) said they were developing this but it was early days.

This picture, where collaboration is the exception, not the norm, is consistent with pharmacists' own accounts of working in isolation and often without clear referral pathways or access to shared records.

Integration challenges: IT, referral pathways and funding

Participants were asked to identify up to three challenges to integrating prescribing into local services (n=60). The top challenges were:

- **Sharing patient records and IT systems:** 63% (38/60), the most commonly identified challenge
- **Clear referral pathways between different prescribers:** 47% (28/60)
- **Funding and payment models:** 47% (28/60)
- **Patient awareness and acceptance:** 38% (23/60)
- **Defining roles, who prescribes what:** 30% (18/60)
- **Getting different professionals to work together:** 28% (17/60)

The primacy of IT systems and referral pathways echoes precisely what pharmacists themselves said. There is no meaningful disagreement between these two groups about what the systemic problems are.

What would help: where there is significant common ground

Analysis of 37 responses to the overcoming-challenges question identified several themes: IT and access to integrated clinical records (12 total mentions across IT themes); pharmacist competency and training (15 total mentions including both trust and training needs); funding (10 mentions); collaboration with other services including better GP-pharmacy communication (15 mentions); and national awareness campaigns (5 mentions) and national mandate (1 mention).

Where other professionals were positive about what would help, they often described exactly what pharmacists described: proper IT infrastructure, clear pathways, and genuine relationship-building. But a significant sub-group added a prerequisite that pharmacists did not: resolving their own doubts about pharmacist clinical competence.

> *"Regular meetings facilitated between different groups, and a better awareness of skill set and competence."*

> *"Digital integration is a major barrier. Pharmacies need a modern IT clinical system that meets both current and future needs and that can integrate with GP clinical systems."*

The competency question: where trust breaks down

A notable theme in the other professionals' data was scepticism about pharmacist clinical competence. Among those who responded to questions about overcoming challenges and supporting infrastructure, coded free text identified: **'I do not trust pharmacists' clinical skills'**, 7 mentions in the overcoming challenges question, and **'community pharmacists lack the clinical training, knowledge and skills to be prescribers'**, 8 mentions in the infrastructure support question. Training not being sufficient was raised in both contexts.

> *"Ultimately pharmacists are not appropriate to be diagnosing and prescribing for medical conditions. They haven't been to medical school, they don't have the clinical training, and their remit is to review medicines and possible interactions or issues and highlight these."*

> *"I also simply find community pharmacists 'not very clinical' so I think it is a real challenge for their competency to get this right. And I say this out of sympathy and empathy, not nasty judgement. I do firmly believe pharmacist prescribing should take place in a GP setting only (or hospital) where there is the system all set up for it."*

These views sit alongside those of other professionals who were active DPPs, who described mentoring community pharmacists to become safe and competent prescribers, and who spoke positively about the value of the role. The data does not support a view that other professionals are uniformly sceptical, but it does show that the minority who hold strong negative views hold them with conviction, and that their views are shaped largely by observations of practice failures rather than opposition to the concept in principle.

> *"From my experience training independent pharmacist prescribers both academically and in clinical practice, there is a significant minority who are over confident in their clinical abilities, they don't know what they don't know. As undergraduate pharmacy education begins to address these clinical competence gaps this issue may diminish somewhat over time but there is a risk that if we try to roll out independent prescribing too fast, too soon then it has the potential to negatively impact patient care."*

Views on value, expansion and NHS commissioning

This section presents other professionals' and commissioners' views on where community pharmacy prescribing currently adds value, their level of agreement with expansion statements, what they think matters most for expansion, and their proposals for making NHS-commissioned prescribing a reality.

Where value is seen, and a significant minority who see none

Among 58 other professionals who answered the value question, **24% (14/58) said they did not think prescribing in community pharmacies added any particular value**, compared to just 1% of pharmacists. Those who did see value identified: managing minor acute illnesses (55%, 32/58); accessible locations for patients (41%, 24/58); ongoing medication reviews for long-term conditions (29%, 17/58); and medicines expertise and safety (28%, 16/58). Reducing GP or nurse workload was selected by only 21% (12/58), considerably fewer than might be expected given that GP workload pressure is often cited as the rationale for expanding pharmacy prescribing.

Free text from the 14 participants who saw no value cited: pharmacists lacking necessary diagnostic and clinical knowledge (4 mentions); pharmacist prescribing increasing GP workload (3 mentions); pharmacists being effective without prescribing authority (3 mentions); it being the wrong setting (2 mentions); and Pharmacy First already having resulted in what they described as reckless antibiotic prescribing (1 mention). A small number acknowledged it could potentially be valuable in the right circumstances or for the right conditions.

"I don't think community pharmacists have the required skills to assess, diagnose and manage patients. These are essential prior to prescription. We see so much reckless prescribing on antibiotics through Pharmacy First and a lack of knowledge of other possible diagnoses for patients in the pathway."

"Fully endorse it. It is amazing. Surgeries love it, patients love it, our pharmacists love it."

Agreement with expansion statements: more cautious than pharmacists

Other professionals were notably more cautious than pharmacists on all expansion statements.

Table 6: Other professionals' and commissioners' agreement with expansion statements

Statement	Mean score (/5)	% agree or strongly agree
Expanding prescribing would improve access to timely treatment	3.61	64% (36/56)
The NHS should commission it as standard primary care	3.48	65% (36/56)
Pharmacists could take on more prescribing if support were in place	3.39	59% (33/56)
Community pharmacy has the workforce and infrastructure needed for scale [commissioners only]	2.44	11% (1/9)

The most striking figure is commissioners: **only 11% (1/9) of commissioners agreed that community pharmacy currently has the workforce and infrastructure needed for scale**. This is even lower than pharmacists' self-assessment of 30%. Clinical prescribers and managers were separately asked whether community pharmacy has the workforce and infrastructure needed: **74% (35/47) said no, 15% (7/47) said yes**. These findings reflect deep systemic doubts about readiness, not necessarily about the long-term goal, but about the current state.

Supporting the infrastructure: willingness alongside concern

Clinical prescribers were asked whether they would in principle be interested in supporting the infrastructure for community pharmacy prescribing, as a DPP, supervisor, or mentor. **55% (24/44) said yes, 45% (20/44) said no**. This is a meaningful signal: more than half of clinical prescribers would in principle support the training pipeline. Free text from the 24 who said yes, described

existing DPP activity, interest in peer support, and willingness to mentor, alongside concerns about time, funding, and the quality of what already existed.

> *"I love my time training and educating other pharmacists. It gives me the biggest buzz out of all the hats I wear. I already support community pharmacists to become safe and competent prescribers as a DPP."*
>
> *"GPS are poorly funded to train and support pharmacists to gain IPP."*
>
> *"Would have to be trained to be a DPP, no capacity or desire to do more training. Time constraints, busy work schedule already. Is there funding attached to do this work?"*

The quotes above reflect the central dilemma: there is goodwill, but it cannot be realised without structural support.

What matters most for expansion: other professionals' priorities

Among the 9 commissioners who answered the question about priorities for expansion (allowing up to 3 selections), the top priorities were pharmacist competence and confidence with clinical supervision (67%, 6/9), consistent and sustainable NHS funding (44%, 4/9), and IT integration (44%, 4/9). Commissioners placed pharmacist competence first, not funding, which is a clear signal about what would need to be demonstrated before they would commission.

What would make NHS commissioning a reality: other professionals' proposals

Free text responses from the expansion question generated themes including: patient safety must be central (11 mentions); adequate funding (14 mentions); pharmacist capability to deliver clinical services (9 mentions); shared access to clinical systems (9 mentions); training quality and standardisation needs improvement (7 mentions); clear scope of independent prescribing practice (7 mentions); relationships between community pharmacists and GPs (7 mentions); and national prescribing protocols and governance (6 mentions).

A sub-group of 8 responses to this question directly said they did not support expansion, a significant minority that should be understood in context. Their concerns centred on pharmacists not being doctors, insufficient clinical training, and preference for directing investment to GP practices instead.

> *"Stop suggesting it and put the funding into providing appointments with qualified Drs. Pharmacists do an excellent job in managing meds, but independent prescribing in undiagnosed patients, or unsupervised protocol-following for illness cohorts is not safe."*

"I think pharmacists have a vital role within the community, we just need more of them. Then the expansion of their role will be a huge benefit to patients and healthcare professionals."

Those in favour often emphasised that the critical preconditions, full IT integration, clear clinical governance, proper funding, and robust training, needed to come first. This is consistent with what pharmacists themselves said, though the order of priority differs: pharmacists want funding to come first and trust will follow; many other professionals want demonstrated competence and governance first, with funding as the enabling mechanism.

Patients

Current pharmacy use and awareness of prescribing

Understanding how frequently patients use pharmacies, what they use them for, and what they know about pharmacist prescribing provides essential context for interpreting their comfort with and concerns about the expanding role.

Regular and purposeful pharmacy users

The 219 patients who participated were regular pharmacy users. **44% (97/219) visited a pharmacy about once a month and 21% (46/219) visited a few times a month; 9% (20/219) visited at least once a week**. Only 6% (15/219) visited less than every few months. The frequency of engagement means this sample brings direct, recent experience of community pharmacy to their views.

The most common reasons for visiting were picking up repeat prescriptions (77%, 169/219), buying over-the-counter medicines (62%, 136/219), and vaccinations including flu, COVID or travel (50%, 109/219). **40% (88/219) went to ask about minor health problems, a figure that directly reflects the patient-facing role pharmacists describe**. A quarter (29%, 63/219) visited for advice about medicines.

Awareness of pharmacist prescribing: most patients know, but some still don't

The majority of patients were already aware that pharmacists could prescribe: **68% (147/216) said they knew this, 18% (39/216) had heard about it but weren't sure, and 14% (30/216) said this was new to them**. The 32% (69/216) who were uncertain or unaware represents a significant group who are potential users of a service they simply do not know exists.

This finding aligns directly with pharmacists' identification of low patient awareness as a barrier to their prescribing activity. A national awareness campaign, called for by multiple pharmacists in free text responses, would address a clearly evidenced gap.

Prior experience of pharmacist prescribing: limited but positive

Only **16% (34/216) of patients had received a prescription written by a pharmacist in the last 12 months**. Among those who had, the most common reasons were minor illness (23%, 7/30), skin conditions (20%, 6/30), long-term conditions (20%, 6/30), and UTIs (17%, 5/30).

Importantly, the vast majority of patients who had not yet had a pharmacist prescription were open to trying: **70% (152/216) said they had not tried it but**

would be happy to do so. Only 12% (26/216) said they had not tried and would prefer to see a doctor or nurse. This represents a large latent pool of willing patients, the challenge is not patient resistance but service availability and awareness.

Positive first experiences, and early lessons

Of the 34 patients who had experienced getting a prescription from a pharmacist, 24 went on to respond the free-text question asking about that experience. Their positive experiences included: that the process was quick (6 mentions); they had an excellent service (6 mentions); and the pharmacist being thorough and professional (6 mentions). Key drivers for seeking a pharmacist prescription included being unable to get a GP appointment (4 mentions), consistent with pharmacists' positioning of their service as accessible and responsive.

> *"It was excellent as I would probably have ended up in A&E otherwise. It was the weekend and the infection in my arm was spreading. It would have been unlikely that I would have been seen on Monday by my GP. The consultation was very thorough and reassuring."*

> *"As this is Scotland, pharmacists have been doing this for years. If I had to wait until a new prescription was delivered via the doctor's surgery I would have been without meds for a few days."*

A small number of patients described concerns or issues: one felt a change in their inhaler wasn't followed up; one experienced reluctance from a pharmacist to prescribe medication they had previously been prescribed; and one described booking an online appointment only to find pharmacy staff seemed unaware of the system. These individual experiences are noted to inform service design, the need for follow-up protocols, clear scope communication, and internal staff training is evident.

Comfort with pharmacist prescribing across clinical scenarios

The survey presented patients with five clinical scenarios of varying complexity and asked them to rate their comfort with being seen and treated by a community pharmacist in each situation. Participants were shown the five scenarios in a random order to minimise sequencing effects.

Overall comfort: high for minor conditions, declining with complexity

The scenarios produced a clear and consistent gradient of comfort, with patients most willing to see a pharmacist for acute, self-limiting conditions and progressively less comfortable as scenarios involved longer-standing symptoms, chronic conditions, or sensitive health decisions.

Table 7: Patient comfort with pharmacist prescribing across five clinical scenarios

Scenario	Mean score (/5)	% very comfortable or comfortable (4 or 5)
1. Infected insect bite	4.47	88% (186/212)
2. Sore throat with mild fever	4.32	83% (173/212)
3. Cold symptoms for 10+ days (possible sinusitis)	4.08	74% (156/211)
4. Contraception	3.71	62% (121/195)
5. Worsening asthma	3.55	55% (115/206)

The infected insect bite scenario (mean 4.47) saw the highest comfort, with **88% (186/212) rating themselves as comfortable or very comfortable**. The picture is more mixed for the asthma scenario, the most complex and potentially urgent of the five: **55% (115/206) were comfortable or very comfortable**, but a substantial 45% were not, with a mean score of 3.55. This divided response suggests that, while the principle of pharmacist prescribing is broadly acceptable even for more complex conditions, there are still circumstances in which comfort drops. The decline in comfort from scenario 1 to scenario 5 likely reflects several factors that patients articulate clearly in the concerns data (Section 12): worry about whether the pharmacist has access to their full medical history; concern about chronic condition management requiring specialist knowledge; and for contraception specifically, questions about privacy and sensitivity. Understanding and addressing these specific concerns could raise comfort further, particularly for scenarios 4 and 5.

What matters most to patients when getting a pharmacist prescription

Patients (n=183) were asked to select up to three factors most important to them when getting a prescription from a pharmacist. The top three were:

- **I can see a pharmacist quickly:** 56% (103/183), speed of access was the most commonly selected factor
- **There's a private space to talk about my health:** 51% (94/183), privacy was the second most important
- **They can access my medical history and other medicines I take:** 49% (89/183)

The top three factors map precisely onto the three most recurring concerns in the free text data: speed (pharmacy's distinctive advantage over GP), privacy (a current infrastructural weakness), and records access (a shared concern across all three participant groups).

Situations in which patients would seek a pharmacist prescription

When asked more broadly about the circumstances in which they would be happy to get a pharmacist prescription (n=210, multiple selection), the conditions that made patients comfortable were strongly pragmatic:

- **If the GP surgery is closed (e.g. evenings and weekends):** 86% (180/210), the most commonly selected scenario
- **If they felt confident the pharmacist was properly trained to prescribe:** 80% (169/210)
- **When it would be quicker than another medical professional:** 76% (159/210)
- **If the pharmacist has access to my medical history:** 72% (151/210)
- **If another medical professional advised me to go:** 71% (150/210)
- **If the pharmacy was easier to get to:** 63% (132/210)
- **None, I'd always prefer to see my GP or nurse:** 4% (9/210)

The fact that only 4% of patients would **always** prefer to see a GP or nurse, regardless of any conditions, is a valuable finding. It confirms that patient resistance to pharmacist prescribing is not fundamental; it is conditional. The expectations patients set (training confidence, records access, GP closure, speed and the condition they are seeking help for) describe what would need to be in place, and in some cases strengthened, for that trust to be realised at scale.

Concerns, enablers and what patients want

This section draws on three open-ended questions in the patient survey: patients' experiences of getting a pharmacist prescription, anything that worries them about pharmacist prescribing, and anything else they wanted to share. Together these provide a rich picture of the conditions under which patients embrace and resist the expanded role.

Pharmacist competence and knowledge are concerns but not dealbreaker

The most commonly coded concern category was "pharmacists' competence and knowledge", with a range of specific worries identified: a pharmacist may lack medical knowledge or experience (24 mentions); concerns about qualifications or competency (10 mentions); GPs or nurses offering a higher standard of care (7 mentions); GPs having more medical knowledge and experience (6 mentions); previous experiences of not being helped (6 mentions); and pharmacists potentially missing important symptoms (4 mentions).

Importantly, these concerns were frequently qualified by condition complexity or context. Patients consistently drew distinctions between minor, self-limiting conditions where they were comfortable, and more complex presentations where they wanted GP oversight.

> *"For everyday conditions like sore throat, cold etc I think a pharmacist is good enough, or for something like birth control or antibiotics for a UTI where I already know exactly what I need. But for a new or more complex condition I think I would always feel more comfortable discussing with a GP."*

Equally common: patients who have no concerns at all

At the same time, the equally common response to the worries question was no concern at all. 'Because I am not concerned about it' was coded 24 times, the same as 'a pharmacist may lack medical knowledge'. 'Because I trust a pharmacist's knowledge and competence' was coded 14 times; 'pharmacists have more medication knowledge than GPs' was coded twice.

> *"No [concerns]. My experience is that they have knowledge and are professional."*

> *"Absolutely nothing. My pharmacist told me why my husband had a change from a 20mg dose to 80mg. I had to wait for FIVE MONTHS for our surgery to make me an appointment. This is quite simply disgraceful."*

Medical records: the most specific and consistent concern

The most commonly mentioned specific concern was about medical records. A pharmacist may not have access to medical notes to review or record' was coded 19 times. This concern is not abstract: patients wanted to know their full history would be available to the pharmacist, that any prescription would be recorded, and that their GP would be aware.

> *"I wondered about two things, which are related. 1. Whether my past history could affect my current 'problem' and therefore how much the pharmacist would know (or have time to consider)... 2. Whether they could access my medical history for that purpose, but the options above seem to suggest they can actually do so (which is news to me)."*

This response illustrates both the concern and its potential resolution: communicating clearly about what pharmacists can and cannot see, and what will happen to the prescription record, is a concrete, achievable way to increase patient confidence.

Privacy: a real and practical barrier to be designed out

Concerns about privacy and the physical consultation environment were coded 13 times ('pharmacies can lack privacy or a confidential space') and featured prominently in the 'anything else' question, 9 mentions of wanting an appropriate private space.

> *"Ours is a very small pharmacy attached to our surgery. People sit and wait for their prescriptions and are inches away from the one counter. Everything you say at the counter can be heard. I wouldn't want to discuss my symptoms there."*

> *"THE PHARMACY FIRST is NOT FIT FOR PURPOSE. They have not got the time or staff to see patients. Nor are there areas one can be seen or heard in private. Until this is corrected there is no point in this service. It's just LIP SERVICE."*

The capitalised frustration in the second quote reflects how important the physical environment is to patient trust. This is a concrete infrastructure issue, not a philosophical one, and it is one where investment in consultation space would directly improve patient confidence.

Concerns about the prescription itself: cost, conflict of interest and follow-up

A distinctive cluster of patient concerns related to the prescription itself rather than the prescriber's competence. These included: financial motivation concerns, 'they may be financially motivated to prescribe' (5 mentions);

uncertainty about NHS prescription entitlement and cost (4 mentions); concern about interaction with other medications (4 mentions); and worry about the best medication being selected (4 mentions).

> *"How is conflict of interest managed, some pharmacists will profit from issuing medication. I am sure most have the integrity to behave appropriately but how can we ensure that profit does not drive decisions?"*

This concern about commercial motivation is real and should not be dismissed. Transparency about NHS vs private prescribing, clear communication about prescription costs and eligibility, and visible governance arrangements would directly address this worry.

What patients most want: joining it all up

The 'anything else' question produced rich additional data. Coded positive themes included: 'I support pharmacist prescribing in at least some scenarios' (12 mentions); 'I feel confident going to my local pharmacy' (11 mentions); 'I feel pharmacists are as qualified as GPs' (9 mentions); and 'I have had a positive experience getting help from a pharmacist' (8 mentions). Patients who knew their local pharmacist were especially positive.

> *"I would feel very confident going to my local pharmacy because I am known to them, having been a customer for many years. They are greatly valued in the community."*

The negative themes, 'I want it to be clearer how and when a pharmacist can help me' (15 mentions); 'I have had a bad experience with a pharmacist' (14 mentions); 'I want pharmacists to receive a sufficient level of training' (10 mentions), reflect manageable problems with addressable solutions: better public information, governance to address poor practice, and visible training standards.

Other considerations patients raised included wanting pharmacies to have **read and write access to their medical records (7 mentions)**, **a clear route to referral to a doctor if needed (6 mentions)**, and **appropriate private space (9 mentions)**. Taken together, these represent a very specific and coherent ask: give the pharmacist the information and environment they need, make sure I can be referred on if necessary, and make sure it's joined up with my GP.

Reflections

This section draws together the three perspectives, community pharmacists, other professionals, and patients, to identify similarities and differences, and what this means for the expansion of independent prescribing in community pharmacy.

Strong agreement on what's needed, but few agree it's in place

The single most consistent finding across all three groups is agreement about what the system needs. Pharmacists, other professionals and commissioners repeatedly point to the same structural enablers: integrated IT systems with access to patient records, sustainable and adequate NHS funding, and clear clinical pathways with governance frameworks. Patients did not raise funding directly, but their priorities – records access, privacy, and confidence that the pharmacist is properly trained – describe the same underlying need for a properly resourced and governed service. There is no meaningful disagreement across groups about what the preconditions for safe, scaled prescribing are.

Where the groups diverge is in their assessment of whether those preconditions are in place, and in their confidence that community pharmacists are currently ready to prescribe safely at scale. Pharmacists believe strongly in the model and in their own readiness; they frame the absence of commissioning and IT as the primary obstacle. A significant minority of other professionals doubt pharmacist clinical competence regardless of infrastructure. Patients are highly specific about the conditions they need: privacy, records access, training assurance, and follow-up.

Where pharmacists and other professionals align

Both groups identified the need for better GP–pharmacist relationships and described these as currently underdeveloped, inconsistent, and dependent on individual goodwill rather than structural design. Both described communication between healthcare providers as a central challenge. Both identified the DPP shortage and training pipeline as a crisis needing urgent investment. And both, including many of those most sceptical about pharmacist prescribing, described the absence of integrated IT systems as the most fundamental systemic barrier.

Where the aligned interest is clearest: 55% of clinical prescribers said they would in principle be willing to support the training infrastructure. This represents a significant untapped resource, but one that requires funded time, clear structures, and professional recognition to become a reality.

Where pharmacists and other professionals differ

The divergence centres on trust in clinical competence, and on the sequencing of solutions. Pharmacists argue: fund it, build the infrastructure, and competent prescribing will follow because the will and the talent are already there. Many other professionals argue: demonstrate competence and governance first, and then the commissioning case becomes fundable. Neither position is unreasonable. Both reflect genuine professional experience.

The data suggests the differences are partly caused by selection effects in what each group observes. GPs who raise concerns about inappropriate antibiotic prescribing are reporting what they see, which is the consequence of poorly designed, under-supervised, under-resourced prescribing services. Pharmacists who describe excellent, integrated pathfinder services are also reporting what they see.

A further dimension of difference is the private prescribing question. Some pharmacists described a reality in which the absence of NHS commissioning has pushed qualified prescribers into private services, creating both health inequity and GP workload. Commissioners, who are positioned to resolve it, are operating in a context where none currently has a well-established commissioned service and most are still in early stages.

How pharmacist and other professional views align with what patients want

Patients largely validate what pharmacists say they can offer: quick access, local presence, and medicines expertise. The 86% of patients who would see a pharmacist if the GP surgery was closed, and the 76% who would see one when it would be quicker, are endorsing precisely the distinctive value proposition pharmacists describe.

But patients also validate key concerns that other professionals raise. Patients want pharmacists to have access to their medical records, a concern that other professionals identify as the top systemic barrier. Patients want to know the pharmacist is properly trained, which is the precondition other professionals put first. Patients want to know their GP will be aware of any prescription, which is the clinical governance and communication challenge both professional groups describe.

In other words: patients are not siding with pharmacists against other professionals, or vice versa. They are independently arriving at the same set of conditions that both groups describe. The patient voice is neither a trump card for pharmacists nor a rebuke to sceptical GPs, it is a specification for what the service needs to be.

Condition complexity should be factored into service design as part of expansion

One of the most practically useful findings from the patient data is the comfort gradient across the five clinical scenarios. Patients are highly comfortable with acute, self-limiting conditions (88% comfortable for the infected insect bite) and progressively less comfortable with conditions involving longer symptom duration, chronic disease management, or sensitive decision-making. This gradient is not simply about risk, it is also about what patients associate with pharmacists' distinctive expertise versus what they associate with GP-level care.

This gradient could serve as a design principle for expanding prescribing in a staged, trust-building way: beginning with conditions where patient comfort is already very high, demonstrating quality and governance, and progressively building towards more complex presentations. This approach would also address other professionals' concerns about pace of expansion, meeting the 'demonstrate competence first' position while still creating a funded pathway for growth.

A lack of continuity for NHS pathfinder services

The data reveals a clear policy gap with direct equity consequences. Pharmacists who qualified during the IP Pathfinder programme built genuinely effective services that benefited patients. The programme's end, without a successor commissioning model, has left those pharmacists prescribing privately for those who can pay, not prescribing at all, or referring patients back to already-stretched GPs. The failure to commission NHS services is particularly problematic for lower-income patients who cannot access private prescriptions.

No amount of goodwill, training reform or GP–pharmacist relationship-building will resolve this without a national commissioning decision. Across all professional groups there is agreement that 'consistent and sustainable NHS funding' is the primary requirement.

The trust gap is closable, and patients show how

The patient data offers a template for building the trust that the other professionals' data shows is missing. Patients' concerns are specific and addressable: communicate clearly about pharmacists' training and qualifications; ensure record access is in place and visible to patients; provide private consultation space; make clear how any prescription will be communicated to the GP; and create a clear route to referral. None of these are impossible. Several are already in place in the well performing services.

What is striking is that patients' trust in pharmacists is not fundamentally dependent on a change in belief about pharmacists' clinical competence, it is dependent on the presence of the governance and infrastructure

conditions that make safe prescribing possible. Patients are, in this respect, asking for the same things that pharmacists say they need and that other professionals say must be in place before they can endorse expansion. All three groups are pointing at the same problems. The question is not whether there is a shared vision of what good looks like; the question is whether the system will be resourced and designed to get there.

Conclusion and Next Steps

This report has set out where community pharmacists, other primary care professionals, commissioners and patients agree, and where their views diverge, on the expansion of independent prescribing in community pharmacy. Four findings stand out as most likely to matter for what happens next.

The aspiration-readiness gap

Pharmacists strongly support expansion in principle with 84% agreeing it would improve patient access, and the same proportion supporting NHS commissioning. However, only 30% think the infrastructure is currently adequate for scale. Funding and IT integration are the two most consistently cited structural barriers, raised independently by pharmacists, other prescribing professionals and commissioners alike.

The DPP and training pipeline bottleneck

The shortage of Designated Prescribing Practitioners is described as a critical, currently unfunded and unregulated barrier that limits how quickly the qualified prescriber workforce can grow, largely independent of how commissioning itself is resolved.

The competence and trust question among other professionals

A significant minority of other professionals remain sceptical of pharmacist clinical competence, views that appear to be shaped largely by specific negative experiences rather than opposition to the model in principle. Alongside this, a majority are more cautious than opposed, and a notable proportion (55% of clinical prescribers) said they would in principle be willing to support the training infrastructure themselves.

The private prescribing and equity issue

Since the IP Pathfinder pilot ended without a national successor, some pharmacists reported shifting from NHS to private-only prescribing, which they described as increasing health inequality and adding to GP workload.

Across all three participant groups, there is very little disagreement about what safe, scaled prescribing requires: integrated IT systems and records access, sustainable funding, and clear governance and escalation pathways. Where groups differ is in their confidence about whether, and how quickly, those conditions can be met.

Next steps

These findings will feed into the development of a national framework for expanding independent prescribing in community pharmacy, led by Q

and NPA, which the NPA and Q will lead. The Framework will be tested and refined with a group of senior stakeholders at a Deliberative Stakeholder Roundtable before wider publication Q finalises it. Thiscovery's role in this project is limited to this Insights Report, presenting the findings at the Roundtable, and working with Q to write up the event notes; decisions about the implications of these findings, and about next steps beyond the Roundtable, are for the NPA to take forward.

Technical Appendix

Survey methods

Survey dates and recruitment. The three surveys were hosted on the Thiscovery platform and open from 22 April to 7 June 2026. Community pharmacists were recruited primarily through NPA membership communications. Other professionals were recruited through NPA and Q networks. Patients were recruited through the Thiscovery platform and Q membership. The survey was completely confidential; individual responses were seen only by the independent research team at Thiscovery.

Eligibility criteria

To participate in the professionals' survey, individuals needed to consent to take part and identify with one of the four eligible professional roles (community pharmacist; GP, nurse prescriber or other primary/urgent care prescriber; practice/PCN/neighbourhood manager without commissioning responsibilities; or NHS commissioning, planning or service design role). 136 individuals who started the professionals' survey were excluded: 73 did not consent, 16 did not answer the eligibility question, 25 were not eligible, and 22 did not answer any substantive questions after eligibility.

To participate in the patients' survey, individuals needed to consent to take part, be aged 18 or over, and have used a pharmacy at any point for any reason. 38 individuals who started the patients' survey were excluded: 35 did not consent and 3 did not answer any substantive questions after consenting.

Sample characteristics and purposive sampling

All three surveys used purposive sampling, inviting those meeting eligibility criteria to participate voluntarily. This approach is appropriate for gathering rich views and experiences from engaged participants but means findings cannot be treated as statistically representative of all UK community pharmacists, all other healthcare professionals, or all patients. Findings represent the views of those who chose to participate.

This research sought the perspectives of three distinct groups; each approached for a different reason. **Community pharmacists** were approached for their direct, frontline experience of prescribing in practice. **Other primary care professionals and NHS commissioners** were approached because their roles shape how prescribing is encountered, trusted and commissioned beyond the pharmacy. **Patients** were approached because their awareness, comfort and expectations will ultimately determine how any expanded service is used. Bringing these perspectives together was intended to surface where views align and where they diverge, rather than to produce a statistically representative picture of any one group.

Notable sample characteristics that should be borne in mind when interpreting findings:

- The pharmacist sample skews heavily towards experienced practitioners (89% with more than 10 years' experience) and slightly towards independent pharmacies (55%). Early-career pharmacists and those in chain pharmacies are less well represented.
- The other professionals' sample is disproportionately made up of GP-practice prescribing pharmacists (38% of the clinical prescribers group) and GPs (36%). This may mean the views of this group somewhat over-represent pharmacist prescribers already embedded in GP settings, who may have distinctive views compared to other primary care professionals.
- The commissioner sub-group (n=9–12 depending on the question) is very small. Findings from this group should be read as illustrative rather than definitive.
- The patient sample skews considerably older (51% over 65, only 8% under 35) and is predominantly White (85%). Younger patients' and patients from minority ethnic communities' perspectives are less fully represented.
- All participants completed an online survey, indicating a level of digital access and comfort. Experiences of those who cannot easily access online platforms are not captured.

Survey design

All three surveys combined closed-ended questions (rating scales, multiple choice, multiple select) with open-ended questions allowing free-text responses. Conditional branching meant some questions were shown only to relevant sub-groups (for example, questions about current prescribing activity were shown only to qualified prescribers using their qualification). Questions were optional; participants could skip any question they preferred not to answer. Full survey questions for all three routes are in Annex 3.

Analysis approach

Quantitative analysis. Closed-ended questions were analysed using descriptive statistics (frequencies, percentages, and mean scores for rating scale items). All percentages are calculated using the number of respondents to each specific question as the denominator. Percentages are rounded to the nearest whole number and may not sum to exactly 100%. Base sizes are reported throughout. Multiple-selection questions allow percentages to exceed 100% across options.

Qualitative analysis. Free-text responses were analysed using content analysis to identify key themes and patterns. Coding frameworks were developed inductively, through systematic review of responses to each question,

grouping similar statements into themes and recording a mention count for each. Themes were reviewed and refined iteratively as further responses were coded. Mention counts reported throughout this report reflect the number of times a theme was raised across responses, not the number of distinct respondents who raised it, since a single respondent could contribute more than one comment coded to the same theme. Quotes were selected to illustrate the range and tone of a theme, not necessarily its most common expression. All quotes reproduced in this report are verbatim from the Annex 2 coding tables, including spelling and grammatical variations, to preserve authentic voice.

Limitations

Self-selection bias. Participants who chose to engage may differ from non-participants, potentially more engaged, with stronger views in either direction, or more invested in the topic of pharmacist prescribing.

Sample imbalances. The three groups are not comparable in size (187 pharmacists, 76 other professionals, 219 patients) and differ in demographic composition, making direct comparison of proportions across groups indicative rather than definitive.

Cross-sectional design. The surveys captured views at a single point in time (April–June 2026) during a period of uncertainty following the end of the IP Pathfinder programme. Views may evolve as commissioning decisions are made.

Causation vs association. Cross-group comparisons and professional role sub-group analyses show associations and patterns but cannot demonstrate causation. Multiple factors influence the views of any individual participant.

Sub-group analyses by demographic characteristics. The sample sizes within each participant group are insufficient to support reliable sub-group analyses by more granular demographic characteristics. For example, breaking the pharmacist sample (n=187) down by region would produce cell sizes too small to draw meaningful conclusions. Findings are therefore reported at whole-group level throughout, and demographic information is used only to describe the profile of participants rather than to test to differences in views across demographics sub-groups. Readers should be cautious about assuming that findings apply equally across all demographic groups within each participant population.

Acknowledgements

Thank you to the 187 community pharmacists, 76 other healthcare professionals and commissioners, and 219 patients who took time to share their experiences, professional insights, and views. The depth and candour of responses, particularly to the open-ended questions, has made this a rich and genuinely informative dataset.

Thank you to the National Pharmacy Association for commissioning this work and to Q for their partnership and network support in reaching participants.

References to annexes

Full data tables for all closed-ended questions, including the best/worst rankings and demographic breakdowns, are provided in **Annex 1: Data Tables**.

Full coding frameworks for all free-text questions, including frequency counts for every theme and the complete set of illustrative participant quotes, are provided in **Annex 2: Free Text Analysis Coding Tables**.

Full participant information, consent forms and all survey questions for both the women's and healthcare professionals' pathways are provided in **Annex 3: Participant Information and Survey Questions**.

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