

# Evaluation of Independent Prescribing in Community Pharmacy Pathfinders

## Final Report

---



A report submitted by the Centre for Pharmacy Workforce Studies  
(University of Manchester) and ICF Consulting

September 2025

Authors:

*Imelda McDermott, Melis Kupeli, Ellen Schafheutle, Sarah Willis (Centre for Pharmacy Workforce Studies, University of Manchester)*

*Aidan Moss, Izabela Jamrozik, and Lucy Loveless (ICF)*

Research team:

*Jon Gibson (UoM), Ugne Litvinaite, Calvin Ho, Roisin Cross, Marianna Smitheram, and Katie Robinson (ICF).*

## Table of Contents

<b>Executive Summary</b> .....	<b>3</b>
<b>Acknowledgements</b> .....	<b>5</b>
<b>Introduction</b> .....	<b>6</b>
<b>Evaluation approach</b> .....	<b>7</b>
<b>Findings from the Pathfinder Programme</b> .....	<b>9</b>
<i>What has been delivered under the Pathfinder programme</i> .....	9
Acute conditions.....	9
Long-term conditions.....	11
<i>Experiences of the Pathfinder programme</i> .....	12
Overall Pathfinder experience .....	13
Clinical governance .....	15
Supervision and support for IP pharmacists .....	18
Skill mix.....	19
Digital.....	21
Funding model.....	23
<b>Discussion</b> .....	<b>24</b>
<i>Summary of findings</i> .....	24
<i>Strengths and limitations</i> .....	27
<i>Actionable messages</i> .....	27
<b>References</b> .....	<b>30</b>
<b>Appendix 1: Case study characteristics</b> .....	<b>31</b>
<b>Appendix 2: Initial Programme Theories</b> .....	<b>34</b>
<b>Appendix 3: Context-Mechanism-Outcome Configuration (CMOCs)</b> .....	<b>34</b>

# Executive Summary

## Background

NHS England launched the Community Pharmacy Independent Prescribing (IP) Pathfinder Programme in 2024 with the strategic aim of establishing a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in primary care. This aligns with the government's vision of community pharmacy becoming more clinical and an integral part of neighbourhood health services. Pharmacists as independent prescribers can independently assess, diagnose, and manage patients, including prescribing medications. NHS England's initial intention was to have 210 Pathfinder sites across 42 Integrated Care Boards (ICBs) that were chosen to deliver various clinical models; existing community pharmacy commissioned services (e.g. minor illness), long-term conditions (e.g. cardiovascular disease, lipid management, respiratory disease), and novel services (e.g. deprescribing, menopause). As of 31 July 2025, 197 sites across 40 ICBs had registered to take part in the Pathfinder Programme. **According to the data from NHS England, Pathfinder sites have delivered over 33,000 consultations, with 97% concluding without the need for patients to be seen by anyone else.** The aim of the evaluation was to provide learning from Pathfinder sites, to assess the future viability and sustainability of IP in community pharmacy, and to develop recommendations for future commissioning.

## Methods

The evaluation, commissioned by NHS England, used a realist evaluation framework to explore how different independent prescribing models were expected to work (or not) and achieve their intended outcomes. Initial programme theories were developed through key informant interviews with policymakers and decision-makers (n=12) and an analysis of expressions of interest submitted by ICBs to NHS England (n=42) to understand the Pathfinder sites' initial reasoning for delivering IP. For the main study, we interviewed **141 participants** (Nov 2024 - July 2025). We conducted **interviews across ICBs** (n=110 from 39 out of 42 ICBs). These interviews guided the purposeful selection of **10 case studies**, encompassing diversity in contextual factors, such as clinical models and pharmacy types (e.g. large chains/multiples, small chains, independent pharmacies). In case study sites, we interviewed IP pharmacists, employers/ owners, other pharmacy staff, as well as other relevant stakeholders, and conducted observations to gain an overview of the environment in which IP was delivered. We also facilitated a stakeholder event to discuss key findings and practical recommendations, once the analysis of data was completed.

## Key findings

Pharmacists participating in the evaluation were broadly positive about the implementation of IP in community pharmacy. They reported increased job satisfaction, linked to the opportunity to apply their clinical skills. Participants noted that IP should not be seen as an isolated service, as IP is not just about prescribing but providing holistic patient care, which requires broader clinical consideration and collaboration with general practice.

Our evaluation identified variations in how **clinical models** were delivered. NHS England identified three clinical models: existing services, long-term conditions, and novel services. In practice, the implementation of these models was primarily dependent on whether they targeted acute or long-term conditions. The **acute minor illness model** was delivered in three main ways: as a walk-in service (a model that functioned as an extension of Pharmacy First but which raised commissioning questions about its distinction from existing services); through GP referrals (which depended heavily on pre-existing relationships); and via referrals from neighbouring pharmacies (which fostered a collaborative environment within the sector). For the **long-term condition models**, Pathfinder sites developed a 'joint partner' approach between the IP pharmacist and the local GP practice. For both approaches, dedicated roles within ICBs were crucial in establishing the relationships and collaboration between community pharmacies and GP practices.

The implementation and long-term viability of an IP service were found to be dependent on five key concepts: clinical governance, supervision and support, skill mix, digital infrastructure, and funding. The programme highlighted the importance of establishing robust **clinical governance**. Pathfinder sites highly valued the intensive ‘handholding’ support provided by most ICBs and they were instrumental in guiding sites through assurance processes and fostering stronger relationships between GPs, community pharmacy and other stakeholders. Securing clear indemnity to deliver IP was challenging due to insurance companies’ lack of familiarity with the new model. Managing the potential conflict of interest between prescribing and dispensing was addressed by requiring mandatory Standard Operating Procedures (SOPs) to separate these roles.

Most sites established formal **clinical supervision**, often provided by a GP, through regular one-to-one sessions. This was highly valued by IP pharmacists as it helped to build their confidence, especially in new clinical areas, and to build GP trust. Informal support networks (peer support) were valued for sharing learning and fostering collaboration.

The delivery of IP required community pharmacies to develop **skill mix** across the wider pharmacy team to ensure the IP pharmacist had the capacity to focus on delivering IP. Some Pathfinder sites used a two-pharmacist model or invested in support staff to free up the IP pharmacist.

In terms of **digital infrastructure**, the nationally designated prescribing system CLEO was a standalone platform intended to enable IP pharmacists to practise as independent practitioners. Most IP pharmacists claimed that the limited access to patients’ full medical histories impacted their ability to prescribe safely. Interviewees underscored the need for an integrated IT system with full read/write access to patient records. Such a system was seen as essential to support seamless patient care, enable true collaboration, and ensure accountability through a clear audit trail.

The **funding model** of using sessional payment was viewed as moving in the right direction, as it was focused on outcomes. However, our interviewees highlighted the need for commissioning strategies that generate predictable patient volumes to ensure a financially viable service.

### Key policy recommendations

1. **National Level (NHS England/DHSC):** A national governance framework is needed to set clear safety standards and define the responsibilities for all stakeholders, while allowing for local flexibility in implementation. This must be supported by a national strategy and framework for indemnity, infrastructure, and ensuring pharmacists have access to integrated patient records and diagnostics. Commissioning and funding models must be redesigned to be sustainable for community pharmacy businesses. This major cultural service shift requires sustained investment and incremental implementation to build confidence across the system. Fundamental to this is investing in the skills and ongoing development of the pharmacy workforce by setting clear expectations around training, continuing professional development, support, and supervision.
2. **ICBs and Neighbourhoods:** While operating within the national framework, local systems should manage implementation to adapt services to local health needs. ICBs are responsible for system-level oversight, monitoring prescribing data and patient feedback to ensure safety and quality. They must actively facilitate access to essential infrastructure (e.g. digital and diagnostics). To achieve this, continued funding for dedicated integration leads (e.g. CPCLs) is essential, alongside funded, protected time for IP pharmacists to engage in local meetings and relationship building.
3. **Employers:** Employers must prepare for the future by utilising changes in supervision legislation to free up pharmacists for more clinical roles. They are responsible for determining the optimal skill mix needed to support safe, quality prescribing services and for helping individual pharmacies implement these new staffing models
4. **Individual Pharmacists:** To focus effectively on prescribing, IP pharmacists must build trust within their own pharmacy teams. This involves empowering support staff and establishing clear roles and responsibilities, ensuring the smooth operation of the pharmacy to enable IP pharmacists to focus on delivering IP.

## **Acknowledgements**

We would like to thank NHS England for commissioning and funding this research.

Our thanks also go to the early key informants whose participation was vital in shaping the initial stages of this project.

We are very grateful to the Pathfinder sites and their system partners who generously gave their time to participate in the evaluation.

Finally, we would also like to thank Alberta Duale and Rebecca Smoley (ICF) for their valuable support in delivering the stakeholder event.

## Introduction

The government's 10-Year Health Plan outlines a transformation for the NHS, underpinned by three major shifts: from hospital to community, analogue to digital, and sickness to prevention. At the heart of this transformation is the proposed development of a 'Neighbourhood Health Service', where pharmacy is set to play a vital role. The plan outlines a vision for community pharmacy that involves a shift from a predominantly dispensing to a more clinical, preventative and digitally enabled role, and an increased role in the management of long-term conditions (such as cardiovascular disease and diabetes):

*Pharmacy will have a vital role in the Neighbourhood Health Service – bringing health to the heart of the high street....Over the next 5 years, we will transition community pharmacy from being focused largely on dispensing medicines to becoming integral to the Neighbourhood Health Service, offering more clinical services...Over time, community pharmacy will be securely joined up to the Single Patient Record, to help them provide a seamless service - and to give GPs sight of patient management. (Fit for the Future: The 10 Year Health Plan for England, July 2025)<sup>1</sup>*

To enable community pharmacies to offer more clinical services, pharmacists need to be able to assess, diagnose, and treat patients, including prescribing medications without needing a doctor's authorisation or being confined to a highly specific patient group direction (PGD). This requires community pharmacists to work as independent prescribers. Independent prescribing (IP) for pharmacists was first introduced in 2006. In 2020, the GPhC published new standards for the initial education and training of pharmacists, making prescribing skills an integral part of pharmacists' foundational education. According to the Community Pharmacy Workforce Survey (published in June 2024), the number of pharmacist IPs in England continues to grow significantly. In 2022, there were 1,494 full-time equivalent (FTE) IP roles, which increased by 34% to 1,996 FTE roles in 2023<sup>2</sup>. This means there is now approximately one independent prescriber for every five community pharmacies in England. As of August 2025, data from the General Pharmaceutical Council (GPhC) shows that one-third (35%) of all registered pharmacists in Great Britain are independent prescribers<sup>3</sup>. This number is expected to accelerate further from 2026, when all newly qualified pharmacists (following a UK MPharm) will be IPs upon registration.

NHS England launched the Community Pharmacy Independent Prescribing Pathfinder Programme<sup>4</sup> with the strategic aim of establishing a framework for the future commissioning of NHS community pharmacy clinical services incorporating IP for patients in primary care. A total of £12 million in funding was allocated to the programme, a portion of which was available to community pharmacies involved in the delivery of the programme. In January 2023, all 42 ICBs were invited to submit an Expression of Interest (EoI) for running a Pathfinder project in their system. Each ICB was asked to set out a clinical model that identified the service within which they would incorporate IP activity, underpinned by a variety of local factors, including the community pharmacy workforce and the needs of the local population. Each ICB was responsible for nominating the sites at which the Pathfinder model would operate. NHS England had planned for a maximum of 210 sites to take part in the programme. As of 31 July 2025, 197 sites across 40 ICBs were registered to take part in the Pathfinder Programme. According to the data provided by NHS England, Pathfinder sites have delivered over 33,000 consultations. As of October 2025, 97% of consultations were concluded without the need for patients to be seen by anyone else and 55% of consultations led to 'prescribing activity' i.e. prescription being issued, renewed, changed, or stopped.

Pathfinders were chosen to test a range of prescribing models and pathways which fall, in the main, into three broad categories; existing community pharmacy commissioned services (e.g. acute minor illness and contraception), long-term conditions (e.g. cardiovascular and respiratory diseases), and novel services (e.g. deprescribing, prescription management, reviewing antidepressants, and menopause services). In March 2025, to increase the number

of Pathfinder sites delivering lipid management to prevent cardiovascular diseases, NHS England invited Pathfinder sites to express interest in extending their existing clinical models to include lipid management. There were over 70 Pathfinder sites that expressed an interest in offering lipid management.

To support the operational delivery of the programme, funding was provided to Pathfinder sites through the ICBs. There was a one-time core set-up fee of £1,500 per pharmacy premises (to cover IT support and participation in evaluation activities), plus an additional set-up fee (if applicable), depending on the service model as agreed with the ICB. Funding was also expected to provide project management and support (including the local commissioning of the Pathfinder sites using a Local Enhanced Service contractual agreement). ICBs were encouraged to share resources where appropriate to optimise the use of project management teams and professional support for developing governance, peer support networks, and clinical supervision and support for IP pharmacists. Payments for IP delivery were structured on a sessional basis. IP pharmacists were expected to deliver up to six sessions per week, up to a maximum of 24 sessions per month. These sessions were designed to be flexible and cover all necessary activities, including patient consultation, documentation, and meetings with supervisors.

The [Centre for Pharmacy Workforce Studies](#) (University of Manchester), in collaboration with [ICF](#), were commissioned by NHS England to conduct an independent evaluation of the impact and learning from the Community Pharmacy Independent Prescribing Pathfinder Programme. The evaluation ran from 1 April 2024 to 30 September 2025.

The aim of this evaluation was to provide learning from IP within community pharmacy Pathfinder sites. The objectives of the evaluation were to:

1. Describe what has been delivered under the Pathfinder programme.
2. Understand community pharmacy contractors and other stakeholders' experiences of the Pathfinder programme and assess the future viability and sustainability of Independent Prescribing in community pharmacy as part of an integration of community pharmacy services.
3. Develop recommendations to inform the future direction of the commissioning of Independent Prescribing in community pharmacy.

## Evaluation approach

The evaluation was approached using a realist evaluation framework. Realist evaluation uses a context (C)–mechanisms (M)–outcomes (O) framework to understand the implementation of complex interventions in practice<sup>5</sup>. It involved developing an initial programme theory to hypothesise how different types of independent prescribing models were expected to work and achieve their intended outcomes, and testing and refining these programme theories.

To develop the initial programme theories (see Appendix 2), we conducted key informant interviews with policymakers and decision-makers (n=12) and analysed expressions of interest (n=42).

The **key informant interviews** were not formal study interviews and were designed as open-ended discussions to explore the perceived rationale behind the programme, its intended outcomes, and the anticipated impact of IP in community pharmacies. Participants were encouraged to share their perspectives on the programme's setup, implementation challenges, and potential for success. Key informants included policymakers, decision-makers, and representatives from national pharmacy organisations.

We analysed all 42 **expressions of interest** submitted by ICBs to NHS England between October 2022 and January 2023 to understand the Pathfinder sites' initial reasoning for delivering IP. The analysis provided preliminary insights into variations in clinical models, the

reasons for choosing those models, expected outcomes, implementation approaches, stakeholders involved in local discussions, challenges expected when delivering the clinical models chosen and the ICB/local IT plan.

Pathfinder sites were expected to go live in April 2024. Due to issues with the implementation of the NHS Electronic Prescribing Solution (EPS) CLEO, no Pathfinder sites could 'officially' go live then or were ready to be evaluated at that time. Only a handful of Pathfinders went live with CLEO in October 2024. To accommodate the delay in Pathfinder sites going live, we adjusted our evaluation approach, and the overall evaluation timeframe was extended until September 2025. However, the compressed data collection period limited our ability to gather longitudinal data as initially intended. It is worth noting that 14 Pathfinder sites began delivering an IP service without the approved EPS system. We included some of their experiences in our evaluation, but including more than a few Pathfinder sites that did not use CLEO would have introduced significant variations in context, such as operational procedures, which could potentially confound the analysis and interpretation of the overall evaluation findings.

Data collection took place between November 2024 and July 2025. We conducted interviews with **141 participants, comprising 126 individual interviews and 6 group interviews**, with each group consisting of 2-5 participants.

- We conducted **Teams/telephone interviews** across ICBs to identify how IP within community pharmacy works in different ICBs, identify where they were in their development, and the learning from implementing IP (**n=110** from 39 out of 42 ICBs). Participants included: Community Pharmacy Clinical Leads (CPCLs) (n=30), IP pharmacists (n=37), and/or the wider stakeholders, such as the Regional Senior Pharmacy Integration Leads (RSPILs), ICB Leads, PCN Leads, GPs, and representatives from chain pharmacies (n=43). Insights from these interviews were used to purposefully select the case studies, ensuring that we captured diversity in contextual factors, such as clinical models and pharmacy types (e.g., large chains/multiples, small chains, independent pharmacies).
- **We conducted 10 case studies** to capture the experiences of the Pathfinder programme in more detail. Our unit of analysis in the case study was ICB rather than Pathfinder sites. In the report, where we refer to "sites", we distinguish between "Pathfinder sites" (which are community pharmacies) and "case study sites" (which are ICBs). The reason behind this was that while Pathfinder sites (individual pharmacies) deliver services at the frontline, their operations and the impact of the programme are shaped by the policies and strategic direction set by the ICB. Pathfinder sites represent "where" IP was delivered, and ICB represented the "how" and "why" of IP being commissioned, supported, and integrated into the wider healthcare system, which will contribute to recommendations for future commissioning of IP in community pharmacy. Following NHS England's priority to focus on lipid management, we selected Pathfinder sites that delivered this model to be part of the case studies. As part of the case studies, we conducted interviews with IP pharmacists, employers/owners, pharmacy technicians, and other pharmacy staff, as well as other relevant stakeholders such as ICB Project Managers and GP/PCN stakeholders (**n=31**). We also conducted observations in pharmacies in all 10 case study sites to gain an overview of the environment in which IP was delivered. During the observation, the researcher had informal conversations with the wider pharmacy team, including foundation trainee pharmacists, locum pharmacists, trainee pharmacy technicians, accuracy checking staff, dispensary trainees/counter assistants, pharmacy assistants, counter staff, and other pharmacy support staff. As Pathfinder sites went live at different times, case study selection was guided by a pragmatic approach. Case study characteristics are provided in Appendix 1.

- We interviewed a few representatives from ICBs which had withdrawn from the programme to understand their reasons for leaving. Moreover, as most of the Pathfinder sites were independent pharmacies, to ensure voices from across the sector were included in our evaluation, we also interviewed a few representatives from chain pharmacies.
- We conducted a stakeholder event on 16<sup>th</sup> September 2025 to present key findings with the aim of facilitating a discussion on practical recommendations for incorporating IP in community pharmacy. The event was attended by 67 participants representing a wide range of organisations, including regional and ICB representatives, IPs themselves, employers and national organisations.

The study received ethical approval from the University of Manchester Proportionate Review ethics committee (Ref. 2024-20036-37105)

## Findings from the Pathfinder Programme

This section presents the main evaluation findings. The findings presented here triangulate data from interviews and case studies to provide a comprehensive overview of experiences across the sites. The Context-Mechanism-Outcome (CMO) configurations are presented in Appendix 3.

The section starts by describing what has been delivered under the Pathfinder programme (addressing Objective 1). This is followed by a description of findings from community pharmacy contractors' and other stakeholders' experiences of the Pathfinder programme, focusing on the Pathfinder experiences relating to clinical governance, supervision and support for IP pharmacists, skill mix, digital, funding model and the viability and sustainability of IP in community pharmacy (addressing Objective 2).

### What has been delivered under the Pathfinder programme

This section outlines the clinical models delivered through the Pathfinder programme, with findings organised according to whether the model targeted acute or long-term conditions. The acute model includes a minor illness model, which is delivered through walk-in services, GP referrals, referrals from Pharmacy First, and referrals from other pharmacies. The long-term condition model includes the management of cardiovascular disease (hypertension and lipid management), respiratory diseases, and novel services (e.g. deprescribing, prescription management, reviewing antidepressants, and menopause services).

The decision on which clinical models to deliver was made by the ICBs. ICBs used selection criteria to select Pathfinder sites (see the 'Overall experience' section below). In addition, it was also based on the strategic priorities of the ICB, the requirements of the model (e.g. some ICBs faced difficulties in arranging pathology), willingness to test innovative models, and the availability of IP pharmacists. Novel services were selected and designed to meet specific local needs or ICB priorities.

#### *Acute conditions*

The minor illness model, seen as an extension of the Community Pharmacist Consultation Service (CPCS) and Pharmacy First, allowed for quicker implementation, building on prior experience in this area and established processes and infrastructure. As this model involves one episode of care, the importance of integration with GP practices was less profound, particularly for walk-in services, compared to other models.

The broad scope of minor illness services often led to confusion among some IP pharmacists in terms of what the service included. Furthermore, there was a difficulty in identifying whether the service should be delivered under Pharmacy First or the IP Pathfinder programme. IP pharmacists, especially those with less experience, preferred a well-defined scope of practice

so that they knew which patients to see and when to refer onward. However, as the experiences of IP pharmacists and patients' conditions varied, different ICBs adopted different approaches. Some ICBs expected IP pharmacists to use their professional judgement and standard operating procedures within the scope of practice defined by the ICB rather than strictly following protocols (PGDs), as this would be too restrictive (seen as not IP and not very different from Pharmacy First). Additionally, having protocols/PGDs would be challenging, as the experiences of IP pharmacists differed. Many IP pharmacists we interviewed reported that they were not confident at the beginning, and wanted to have clear, limited guidance, such as the PGDs (as many pharmacists seemed risk-averse). To address this, arranging clinical supervision and support and building the confidence of IP pharmacists were fundamental in building IP pharmacists' confidence (see Supervision and support for IP Pharmacists section).

Other models included **referrals from GP practices, other providers such as NHS111, or urgent care treatment centres**; in some cases, referrals were made from other **community pharmacies**, which offered Pharmacy First but where the patient's conditions were outside of strict PGD criteria.

Our interviewees reported that **walk-in** services gave patients the impression that they could be seen quickly; however, they argued this may not be realistic in practice, as IP pharmacists may be doing another consultation or the pharmacy had limited consultation space (see 'Infrastructure' section). Other pharmacies operated an appointment booking system to overcome this issue but found that appointment slots could quickly fill.

Where neighbouring pharmacies referred patients to Pathfinder sites, this facilitated a more collaborative relationship between community pharmacies, rather than one of competition. An important outcome of referrals from Pharmacy First to Pathfinder (either within the same pharmacy, branches of the same pharmacy chain or from other pharmacies) was that the patient was seen at a pharmacy, which reduced the 'bounce back' from Pharmacy First to GP practices. However, a potential drawback was that patients might not be able to be seen at their nominated pharmacy, potentially requiring them to travel to another pharmacy:

*The other pharmacies are referring to me as well, and that is really nice because I don't think we've ever worked like that in community pharmacy. We've always been really isolated and usually, well, most pharmacies only have one pharmacist on duty, so you're just quite used to working on your own independently and learning about this collaboration and how important that is and drawing on this network of other businesses that are pharmacies that you're all linking in and building this network, it's really, really good, really positive. (Lead IP pharmacist, ID34)*

Findings from the case studies provided a detailed description of the implementation of the minor illness model. GP practices, especially those with a close working relationship with IP pharmacists, co-developed a process to triage patients to Pathfinder sites:

*I'm a partner at this surgery, we work closely with the pharmacy downstairs, who rent part of our building. We were approached to let us know that they were part of the Pathfinder Programme. I think this was a win-win for us because we realised we could be smarter with our triage process that comes through our eConsult system, which is all done...the triage is all done by GPs. So, I created a SOP [standard operating procedures],...for us to triage our patients correctly into the Pathfinder remit. Whereas, previously, we had a SOP that only allowed us to triage into the CPCS national remit, so a handful of conditions that they could prescribe for in the pharmacy. (GP, ID56)*

From the **case study observations**, we found variations in the length of IP consultations. For example, at Site 5, which offered an extended minor illness model, during the day of the observation, two patients were walk-ins and were seen under IP. Each consultation took around 15 minutes. However, in general, from both observations and interviews, we found that an IP consultation can last over 30 minutes.

## Long-term conditions

The scope of long-term condition models focuses on continuity of care over a longer period and greater management of the condition, rather than one-off or episodic care. This model included the management of cardiovascular disease (hypertension and lipid management), respiratory diseases, and novel services (e.g. deprescribing, prescription management, reviewing antidepressants, and menopause services). For example, a hypertension service could include the initiation of therapy upon case finding and continuation of therapy, lifestyle advice and/or planning annual reviews. The scope influenced operational arrangements (e.g. transfer of care between the community pharmacy and the GP practice) and infrastructure needs (e.g. the need for access to pathology).

Most of the management of long-term conditions relied on GP referrals, where GP practice staff identified eligible patients, making this collaboration essential for ensuring the safe transfer of care and providing a more integrated service for patients. **Securing GP buy-in** was identified as crucial to ensure effective collaboration. Engagement between Pathfinder sites and GPs (including GP practice staff), which needed to be facilitated by the ICB if there was no existing relationship, was vital for co-designing services that suited the local context and infrastructure. This collaboration helped define the scope of the service, establish efficient referral pathways, and align the new community pharmacy offerings with existing primary care provision. Some GP practices developed a process where the GP practice staff searched patient records to find eligible patients:

*We're in the final stages of developing the CVD [cardiovascular disease] prevention model and this has probably been the hardest one so far, defining what that looks like, getting the buy-in from the local practices is really important. Because although it's going to be run independently, you can't really do something that's going to involve initiating long-term therapy without close collaboration with those GP practices who are going to take on that care long-term. (ICB senior pharmacy lead, ID114).*

Beyond the structural integration of the service, GP support was also vital to build IP pharmacists' confidence in delivering IP. GPs were found to provide clinical supervision and ad hoc advice (see 'Supervision and support' section). GP buy-in, coupled with peer support networks, created a collaborative environment where IP pharmacists felt able to thrive in their roles.

**Access to pathology** was found to be one of the major challenges in implementing long-term condition models and novel services, which require blood test results (see 'Digital' and 'Supervision and Support' sections). Pathfinders' experiences from the delivery of cardiovascular diseases and lipid management highlighted the lack of established **pathology infrastructure** as a major hurdle. A key difficulty was the significant local variability in pathology arrangements. Our interviewees raised concerns about IP pharmacists' lack of access to pathology systems - ordering them and seeing results in a timely way without involving GPs, and some expressed concerns about IP pharmacists' lack of the necessary skills to review blood test results:

*GPs are worried about... if the community pharmacy prescriber tasks the GP team on a blood test that needs to be done, who is going to review the blood tests. The GP practice is of the opinion that if you order a blood test, you should be taking responsibility for it, but we also come across a challenge that our community pharmacy Pathfinders don't have access to GP systems in that way. [...] we have to find a way to make sure we put checks in the system in that process, so that the Pathfinder prescriber knows at what point to check whether the bloods have been done, read, interpreted and fed back to them. So, there's so many loopholes, simply because the Pathfinder sites cannot order the blood tests themselves... So, that's a big bottleneck for that service. (ICB senior pharmacy lead, ID 118)*

ICBs adopted several different approaches to arrange access to pathology. Some ICBs facilitated access to the GP's IT system (i.e. EMIS or SystmOne) for IP pharmacists, enabling them to request blood tests, view results, and book follow-up appointments. This model enabled IP pharmacists to manage the entire patient pathway for conditions such as hypertension, from initial testing to ongoing monitoring:

*We have got access to the GPs EMIS...I can order blood tests via EMIS... Those blood tests, I can view...everything on EMIS when the results are in. For blood pressure, I might also need to... [fit an] ambulatory blood pressure monitor. ...We do that fitting here. What that does is basically determine what the patient's blood pressure is over a 24 hour period. That gives me a good indication of where they are with their blood pressure. The results come directly to me. (IP pharmacist/ employer, ID73)*

In Pathfinder sites where IP pharmacists had seamless access to GP systems, they found it very helpful. In others, ICBs arranged a workaround where a GP had to order blood tests on the pharmacist's behalf. However, this raised concerns about professional accountability and increased GP workload. Another approach was to integrate blood test requests into PharmOutcomes for hypertension consultations, whereby IP pharmacists would ask the patient to contact their GP practice to arrange for a blood test, although the feasibility of this was highly dependent on local arrangements:

*We have integrated blood test requesting into our PharmOutcomes hypertension consultation template where IPs are able to choose what blood test results they'd like requested and advise the patient that they need to get the blood test within two weeks, and then the patient will have to arrange it with their GP surgery. This will also be sent via a post event message to the GP surgery, the specific individual at the GP surgery, for example, who will be able to see what blood test requests the IP has listed and they will then upload this onto the GP record onto us, and then the patient can ... either contact the patient to book the blood test in or the patient will have to contact the surgery to book that blood test. (ICB leads, group interview, ID87)*

In implementing long-term condition models and novel services, most Pathfinder sites adopted a **phased implementation approach**. This approach was found to enable IP pharmacists to gradually build their confidence, with GP support, which in turn meant that GPs and their teams would build their trust in IP pharmacists' skills while ensuring patient safety. For example, a Pathfinder site delivering a hypertension service adopted strict inclusion criteria at the beginning, focusing on low-risk hypertension patients. As the clinical model matured, and as the IP pharmacist gained confidence and the GP's trust, the criteria were progressively expanded to include higher-risk categories. Similarly, in most Pathfinder sites, lipid management was offered to a narrow group of patients to ensure that it could be delivered safely with a demonstrable outcome, rather than introducing a wide range of lipid management models to a large number of patients.

## Experiences of the Pathfinder programme

This section describes the experiences of community pharmacy contractors and other stakeholders involved in the Pathfinder programme. However, as the majority of Pathfinder sites were independent pharmacies, with a small number of Pathfinder sites from larger pharmacy chains, we invited a small number of additional interviewees from multiple pharmacies' head offices (chains), which were less involved in the Pathfinder programme. Furthermore, we interviewed ICBs who had withdrawn from the programme to understand their reasons for leaving and thus build a comprehensive understanding of its implementation.

## Overall Pathfinder experience

This section describes the overall experiences of Pathfinder sites, from producing the expressions of interest to the implementation and delivery of IP clinical models in community pharmacy.

Our interviewees highlighted that the evaluation criteria for Pathfinder sites selection by ICBs were extensive, focusing on the pharmacy's track record, operational readiness, and existing relationships within the primary care system. Key areas of focus included the pharmacy's **clinical track record**, such as a history of delivering services and the experience level of the IP pharmacists. **Operational readiness** was also critical, considering factors like staffing levels, consultation room availability, and overall capacity. The expressions of interest submitted by Pathfinder sites were assessed by ICBs on their **willingness to engage with GPs and work in an integrated way**, looking for evidence of good relationships with local GPs and with some ICBs focused on sites' relationships with their primary care network. Finally, wider **strategic factors** like pharmacy location and local deprivation levels were also taken into consideration. Hence the selected sites were usually high-performing pharmacies, often with strong pre-existing relationships with GP practices and a track record in delivering clinical services. This may not represent typical community pharmacies in England, many of which may lack the same resources and readiness.

Some ICBs took a strategic approach by matching the expressions of interest from individual pharmacies with separate expressions of interest from local PCNs. This approach ensured that selected Pathfinder sites were located within a PCN that was also actively interested and committed to supporting the programme. This proactive method of ensuring GP and PCN buy-in from the outset was seen by most of our interviewees as a key facilitator for successful implementation.

While selection processes were robust, they were not without their challenges. For ICBs, running the evaluation panels, scoring applications, gathering intelligence from internal and external stakeholders, and conducting site visits was a significant use of resources. For the community pharmacies, the lengthy application process added a considerable burden to their existing workloads, which may have deterred some suitable candidates from applying. Furthermore, for those pharmacies which were part of multiples, this process decoupled applications from individual pharmacies from the wider structures and approval processes of the multiples.

With 42 ICBs adopting different processes for the submission of expressions of interest, the process of applying to be Pathfinders was seen as challenging for chain pharmacies, especially larger ones, as there was an expectation/ need to engage with 42 different processes:

*It's all very difficult to understand what's going on at a local level because it's all been about local pharmacists talking to local commissioners. It's really after the event that I've tried to find out how many of [our company's] pharmacies had managed to secure the Pathfinder. The pharmacies that were selected aren't necessarily the ones that I would have chosen, nor the pharmacists that I necessarily would have chosen for the pilot. ... The first challenge for the actual Pathfinder is, say, knowing which pharmacists and which pharmacies have been involved. The second challenge has been getting feedback from a programme level on the successes on a daily, monthly, six-monthly basis as to how it is going. Because I've had very little feedback at an organisational level. Why is that important? It's important because the more I can understand the service ... and the more the superintendent can understand the service, the more that we can apply additional resources, the more that we can share the feedback, the more that we can share our own personal experience of services. If I've got in the future 250 individual locally commissioned services, the chances of it being a success*

*are very slim...it is very difficult trying to coordinate at an organisational level 250 different service models. (Representative from chain pharmacy, ID130)*

In terms of the Pathfinder programme itself, most of our interviewees described the programme as a crucial opportunity to utilise the skills pharmacists had gained over many years. It provided an opportunity to integrate community pharmacy into the wider healthcare system. Many IP pharmacists described increased job satisfaction and how the IP pathfinder services allowed them to use their clinical skills to much better effect:

*From our point of view outcomes is we are now finally using our IP skills which is why we did the IP course many, many years ago. So, that's been really, really good. Obviously, this is another step of collaborating with the GP surgeries and the local partners. So, that's been a real benefit as well for the pharmacy. ... I think, it's moving in the right direction. (IP pharmacist/employer, ID76)*

*And then obviously I've come from this background where I was very deflated with community pharmacy, I was actually going to leave, and really wanted to use my clinical skills and really wanting to utilise, I suppose, the prescribing qualification as well. So Pathfinder saved me, really, because it just gave me that something that I was looking for, really given me a lot of job satisfaction but also spread that background of me understanding how important collaboration was, then I think when the two of us sort of collaborated on this project, it was just, like, a dream where...you know, he's really supported me, really pushed me out of my comfort zone and enabled me to have a massive upskill. (Lead IP pharmacist, ID34)*

There was a general view that IP should not be seen as an isolated service. This was because IP was not just about prescribing but also about providing holistic patient care, which requires broader clinical consideration and collaboration between IP pharmacists and the GP practice:

*There's a lady recently, she had low pressure, she was referred to me and it took me a while to get her to open up, and I suppose that's a bit of a skill, isn't it, trying to take that history and really get that patient to open up to you. ...she'd had some traveller's diarrhoea, and I was thinking, okay, so she's dehydrated, this is why the blood pressure's dropped down. And I referred her to the GP, organised a load of bloods that I felt were relevant as well because she had the sort of tired all the time symptoms as well, and she came back to me for a review of her blood pressure and since then she'd had all these bloods, there were loads of things that were spotted, low iron, and also blood in her stool, so she was sent for a colonoscopy and it turned out that she'd been overdosing on ibuprofen. That was the cause of this issue that she'd been having. ... I could have just so simply treated the low blood pressure...And again, it's that collaboration...Setting up the bloods that I knew needed doing, sorting out the GP follow-up, it comes back to that collaboration...So I think it's just not looking at that one problem because often there's other things that are connected." (Lead IP pharmacist, ID34)*

While Pathfinder sites were provided with dedicated funding to be part of the Pathfinder programme, a common view was that Pathfinder participation could cost more than the funding provided. Chain pharmacies noted the need for community pharmacies, as private businesses, to be profitable as a necessary consideration to continue offering IP. Independent pharmacy owners also made this point, as many worked additional hours, driven by the motivation to demonstrate what pharmacy could contribute. Our interviews with a couple of ICBs who had dropped out of the Pathfinder programme also chimed. They welcomed the Pathfinder programme, but the primary reason for dropping out was a lack of capacity and resources, as well as a delay in implementing the approved electronic prescribing solution, CLEO. Setting up IP Pathfinder participation required a significant amount of time and effort to build relationships with system stakeholders and establish the necessary support mechanisms. Recognising this substantial workload, ICBs funded project management role to

support implementation. Even with this support, staff found it difficult to cope with the demands of the Pathfinder initiative on top of their existing duties.

The roll-out of the Pathfinder IT system CLEO was significantly delayed, which contributed to a small number of Pathfinder sites withdrawing from the programme. However, many Pathfinder sites were able to find workarounds which allowed them to start delivering IP. The challenges and proposed solutions will be described in further detail in subsequent sections.

Patient experiences were not sought as part of this evaluation. However, IP pharmacist and other pharmacy staff commonly described how patients were "very happy with the service", satisfied to be seen quickly and leave with their prescription dispensed. Even when patients had been hesitant at the outset or needed to be persuaded by GPs to be referred to the pharmacy, they left satisfied. Furthermore, during our interviews with Pathfinders, we came across some regions/areas/sites that had set up surveys to gather patient experiences. Interviewees reported that these local surveys had found that patients valued IP in community pharmacies for two main reasons: quicker access and longer consultation times. However, our interviewees noted that the longer consultation times were partly due to the nature of the Pathfinder programme, which was designed to facilitate learning and identify challenges. Additionally, many IP pharmacists we interviewed felt this extended time was essential for providing safe, high-quality patient care, allowing for proper history-taking and detailed record-keeping:

*We've set up a patient experience survey with our comms and engagement team, so we know the patient feedback which is very positive. So this is about access. We need to be very mindful, the IP Pathfinder is not real life, because we're not saying you've got to see a patient every ten minutes like they say in general practice, we are saying if it takes half an hour it takes half an hour. Because we've been told by the national team it's not about the volume, it's about the learning. So patients are getting a good experience because they've got a clinician who isn't on the time quite the same as in general practice, so I think patients are getting really good consultations where people can maybe get into some of the detail they wouldn't normally have the time for doing. So yeah, feedback is really positive from patients around how things were managed and how effective it was (Community pharmacy clinical lead, ID23).*

### Clinical governance

Implementing the Pathfinder programme highlighted the significant challenges of establishing robust clinical governance for novel services within community pharmacy settings, which ICBs and Pathfinder sites worked hard to overcome. Most interviewees describe the challenges in preparing the necessary documentation, such as Standard Operating Procedures (SOPs) and risk assessments. This was particularly challenging for **independent pharmacies**, which often lacked the dedicated resources and staff to manage these complex requirements amidst existing workloads. In contrast, **chain pharmacies** could frequently rely on support from their head offices, which had experienced staff to handle governance and documentation, creating a disparity in the level of support needed.

Most ICBs supported Pathfinders in setting up clinical governance. This often took the form of **'hand-holding' support** from dedicated Project Managers or Community Pharmacy Clinical Leads (CPCLs), who guided sites through the documentation and assurance processes.

*We had a... document for assurance procedures, so it's quite a lot, covering everything from patient confidentiality to... through the scope of practice for each pharmacist. And we collected various documentation from the pharmacist and we took that as proof that they met the requirements for the SLA [service level agreement], and the clinical governance documentation that we had in place, the assurance documentation. So many, many criteria we had within our document, and we went through each one meticulously with the*

*pharmacist and we asked for documentation from DBS checks, to scope, to the actual assurance documentation related to the model that we were operating.... we were meticulous and we actually reviewed all of their SOPs and their business continuity plans to ensure that indemnity cover. So many, many aspects where we went through everything with a fine-tooth comb to ensure that they complied with our assurance arrangement (Project Manager, ID131)*

A small number of ICBs saw clinical governance as something that the providers/contractors should be responsible and accountable for. Their approach was to set clear safety and governance standards through a robust Service Level Agreement (SLA), with explicit expectations placed on the pharmacy's professional and contractual responsibility to create its own internal processes to meet those standards. While ICBs provided templates for documents such as risk registers or conflict of interest forms, some ICBs saw it as the community pharmacy contractors' responsibility to ensure the processes were tailored to each site :

*I am mindful that I could sit here and write documents for them but actually that wouldn't fit their practice, and actually if I write the document I'm also liable for that, so I need to be very careful... So we've got a national service level agreement template. The governance bit was a bit empty so we had to fill that in, so I agreed all the governance processes to make sure it's safe. So we are essentially saying to the pharmacies this is the SLA [service level agreement], as a contractor you're responsible and accountable for making sure that you can meet this SLA and the requirements of it and that the prescribers that you have working as part of the Pathfinder programme are fit and suitable. So that feels quite handwashed but that is how commissioning should work... that sounds like we've not helped, that is not the case, but we've very much made it clear it's their responsibility. But what we've done is we've set up a collaboration group, so all the IP sites, we've got a joint Teams chat... I know some contractors shared their resources with each other... a lot of them weren't very clear on how they should be capturing their conflict of interests, so we shared a generic conflict of interests, a declaration form. So we have actually created quite a lot of resources... from a governance point of view, we've not given them governance documents but we've supported them with templates, for example. (Community Pharmacy Clinical Lead, ID23)*

A small number of ICBs had done preliminary work on standardising non-medical prescribing (NMP) policies within the ICB to align and embed IP in community pharmacies within the existing processes. However, this was dependent on having someone in the ICB with knowledge of past and existing policies:

*We came up with an assurance process for the Pathfinder programme. So, there is work ongoing in our ICB to try and harmonise some of this stuff and come up with one ICB level and NMP policy, and I am involved in that. So, I'm hopeful that the work that I've done will be taken into consideration when we come up with [name of a region] policy. All we have at the moment is a best practice guide, an NMP best practice guide, but it's not a policy, it's slightly different. ...the NMP leads in those localities are happy with that process, they've seen it and agreed with it. But again, it's something separate for community pharmacy and it shouldn't be, the aim of what we've tried to do is to try and embed our community pharmacy IPs into existing pathways rather than trying to create new things for them. Because if we create new things, it just isolates them and makes them look different and separate and we don't want that." (Community Pharmacy Clinical Lead, ID4)*

Several of our interviewees identified the **potential conflict of interest** related to prescribing and dispensing being done by the same pharmacy. To manage this potential risk, some ICBs requested that each Pathfinder site create a well-defined SOP that clearly differentiates the IP pharmacist's roles as prescriber and dispenser:

*Pharmacists issuing medicines under a PGD [patient group directives] essentially do it. So I think you have to think about it in context and actually what's best for the patient. And if I was the patient and I'd seen that pharmacist, I wouldn't want to go somewhere else to get it dispensed, you'd want to get it dispensed in the same place. So I think you have to be a bit pragmatic about it, but I do think it's really important to make sure there's an SOP in place to separate the prescriber from the dispensing wherever you can and mitigate the risks as much as possible. So as part of our assurance processes, all our sites have had to declare that they have got a) SOPs in place for the whole service and b) the particular one around separating the prescribing and the dispensing. And actually the sites we've chosen either all have two pharmacists or have an ACT checking technician so that the pharmacist, [as a result] is removed from the accuracy checking as best they can be." (Community Pharmacy Clinical Lead, ID42)*

Many of the IP pharmacists that we interviewed noted the challenges around indemnity. A primary issue was the novelty of the service itself, which created a considerable risk, as it offered little assurance if things were to go wrong. In response to this perceived risk, some IP pharmacists took proactive measures by implementing a system of self-audits. This internal quality assurance process was designed to generate tangible evidence that they were doing things correctly. While this strategy enabled the IP pharmacist to feel more secure and accountable for their practice, they recognised it as a personal burden rather than a sustainable, long-term solution:

*In terms of governance...everything has been provided by the ICB.... One thing that I'm very disappointed by is, there was no indemnity insurance provided, they just said, go and get your own. So, you ring up ... whoever it is that your indemnity insurance company is, and you say, can we have some indemnity insurance for this? And they're like, we've never heard of it, we have no idea what it is and because we don't know what it is, we can't give you any indemnity for it (IP pharmacist, ID19)*

*What I don't like about the insurance, is that it's all very vague, and so it states that, so long as you're working within your competence, then it's fine, which is all fine until something goes wrong. So there's not a whole lot of guidance from the insurers, it's left very, very open, which to me seems like a big risk, which is why we're doing these internal audits on ourselves, to show that we are doing things correctly. But I think a broader framework is required, if you were making it a national service, or expanding the Pathfinder (IP pharmacist/pharmacy owner, ID58)*

Indemnity cover created further challenges for IP pharmacists who worked across sectors because it was too costly for the pharmacist to be indemnified as an individual, which limited their ability to prescribe in different settings:

*So initially, we've been insured with two different providers over the course of the programme. ... Both have been happy to insure us but there has been an increase in our premium to cover that risk. I don't think the premium has gone up as much as it would do normally for prescribing. So, I have my own insurance as an individual for, you know, indemnity as a pharmacist. To add prescribing onto my own personal indemnity was going to cost me around about a thousand pounds a year. I think [name of insurance companies] have charged us about 50 pounds a year. So, I've had to take the decision not to add it onto my own indemnity, so the indemnity is just through the pharmacy, ... which is indemnifying everything I do anyway. But as I say, my personal cover is if I'm locuming somewhere else or they're working in the GP practice that our pharmacy indemnity doesn't cover me for those bits. And so, I'm not able to do prescribing outside of this pharmacy, so I can't prescribe when I'm in the GP practice, I can't prescribe, say, if I'm in a different branch because, as I say, the cost of adding that indemnity on is too prohibitive to do it on an individual pharmacist basis (IP pharmacist/ pharmacy owner, ID58).*

## Supervision and support for IP pharmacists

Supervision and support for IP pharmacists were identified as crucial. Many ICBs facilitated clinical supervision, ad hoc clinical support, and established peer support networks, such as WhatsApp groups, and regular drop-in calls. IP pharmacists found these efforts helped them feel supported and part of the general practice team, which enhanced their motivation and provided a sense of belonging within the wider healthcare system.

Our interviewees reported different ways of delivering **clinical supervision**, in terms of whether the supervision was conducted one-to-one or in a group, and who was providing the supervision. Most Pathfinder sites had a formal arrangement put in place, whereby a clinical supervisor, often a GP, met regularly with an IP pharmacist to discuss cases. These sessions were a structured way to review clinical decisions, address any issues (IT, admin, or clinical), and discuss and reflect on patient cases. Some GP supervisors mentioned meeting with an IP pharmacist on a weekly basis to discuss their experiences since they started offering IP services. IP pharmacists claimed that these arrangements provided valuable opportunities for IP pharmacists to have a **GP supervisor**.

*We have ... a GP contact at the surgery. He's one of the partners, a senior partner and we have a monthly meeting, monthly tutorial with the clinical supervisor. And then the doctor is on call for any queries for us. ... So, on a weekly basis we have linkage with them and we discuss and, ... go through any cases that we feel that need a second look or anything that we need to check regarding the patient and the service and, you know, blood tests, et cetera. So, we're having that supervision from a local GP practice. (IP pharmacist/pharmacy owner, ID76)*

*We have a good relation with one GP surgery, so that actually helps a lot, because they are someone that we can contact in terms of, like, let's say if I need more training, then yeah, they would set up with us to a GP who was willing to help us do the training, let's say, about using a stethoscope, or other things. So there is clinical supervision, and then on top of having another pharmacist who is also a prescriber, I can also ask for, let's say, the GP's opinion if it's a difficult case. And also, actually, there's also help from the ICB itself. So they have set us up for a few prescribing training sessions with a provider, where we can meet with other Pathfinder sites and do the training. So there is always support for the clinical supervision, I think. Which is a thing I'm grateful for." (IP pharmacist, ID29)*

GP supervision was considered by most IP pharmacists as essential for building the IP pharmacist's confidence, **especially when delivering long-term and novel clinical models**, which required joined up care during longer-term patient management. Another mechanism to do this was by employing a **lead clinical mentor (a pharmacist working in a GP practice)** to provide clinical supervision for IP pharmacists in the ICB.

Another type of support were **peer support networks**, which were networks of IP pharmacists in the regions who meet and discuss issues related to operational and clinical support. They could share updates, ask questions and bond with 'peer' IP pharmacists. Many ICBs facilitated virtual meetings held at regular intervals to provide a platform for IP pharmacists in Pathfinder sites to come together to discuss interesting or challenging patient cases. They could discuss anonymised patient cases with the group and receive advice from their peers almost instantly:

*All of the pharmacists from the independent prescriber Pathfinder sites are in a virtual meeting, and it's a meeting where they bring interesting cases or cases that they weren't sure what to do.. (...) The other thing that we do have is we have a WhatsApp group, so all of the sites are on a WhatsApp group which I'm part of as well, and so people are anonymised, clearly there'll be no patient identifiable factors but it'll be, oh, I had a case of this, this and this, what do people think? (GP Clinical Supervisor, ID51)*

One ICB commissioned the regional training hub to provide clinical and peer support for IP pharmacists:

*From a clinical perspective we were given funding from NHSE for clinical and peer support. So we have commissioned clinical and peer support through our [regional] primary care training hub that essentially enables the IPs to have one-to-one clinical support sessions every month and also peer support sessions. (Community Pharmacy Clinical Lead, ID23)*

Similarly, from our case study interviews, we found that IP pharmacists widely valued the clinical supervision along with peer support networks that facilitate shared learning and confidence-building. However, an unintended consequence of supervision by the GP was **an increase in GP workload**. Although funding was available, it was thought that the amount was inadequate and the current shortage of GPs made it very challenging to absorb this additional demand on their time:

*There's a bit of work for the GP within this. So, they have to provide some supervision. They are paid for that, but they still have to do it, so they have to be able to have the capacity. So, one site had a difficulty in that one of their pharmacists left and they felt they couldn't have capacity at that point.... GPs are very...are very busy, they're under a lot of pressure, so we're adding and we're asking them to support something else.... There is some funding, but it's not a massive amount. And actually, we were obviously trying to sell it on the concept that it would take work away from them. (Programme Manager, ID55)*

In areas where community pharmacies had no existing relationship with their local GPs, CPCLs played a crucial role in facilitating relationship building and establishing a support system for IP pharmacists. In a clinical model where IP was dependent on GP referrals, IP pharmacists claimed that it was important that they had direct access to the duty doctor at the GP practice for urgent on-the-day patient discussion (in the same way as other GP practice staff) so patient cases could be escalated quickly if needed. Some IP pharmacists had successfully built a good working relationship with practice staff. This was facilitated by the practice-employed pharmacist, practice manager, and the admin staff:

*The good thing is... I've built a relationship with the surgery where I am able to call in for their help essentially [...] Not specifically a certain GP, but it's more with the pharmacist team and the management team and so the admin staff more.... it's very helpful in the sense that, ... because we have that relationship, they are a lot more willing to give their direct contact numbers, the direct extension lines, for me to be able to get through past the queue system on the normal... Because normally we'd call... as a pharmacy, you know, we'd have to go through the normal line or drop them an email, which would take some time. (IP pharmacist, ID80)*

### **Skill mix**

The need to develop the pharmacy team and to ensure adequate staffing was identified as essential for the delivery of IP, so that the IP pharmacist had the time and capacity to deliver uninterrupted IP consultations. Many Pathfinder sites used **a two-pharmacist model** in order to safely and effectively deliver IP. While this model was considered ideal by some, other sites implemented skill mix models. An effective skills mix model ensured sufficiently trained staff, with roles and tasks clearly defined and communicated to the team. This model relies on the IP pharmacists having strong understanding of their team and placing trust in their capabilities. Having a good skill mix with sufficient staff capacity meant that the IP pharmacist could fully dedicate their time to clinical consultations without disrupting the pharmacy's daily operations. In the two-pharmacist model, the other pharmacist could handle all other duties which required a pharmacist, including delivering other clinical services like Pharmacy First:

*There's no way a pharmacist could do this service [IP service] as well as running the normal activities of the pharmacy. So, it is having it set up where it is separate, so you've got the*

*pharmacist out there and the pharmacist doing the clinics. (IP pharmacist/pharmacy manager)*

Our interviewees acknowledged that the two-pharmacist model was not sustainable if there were not enough patients being seen at the pharmacy, making it difficult to justify the cost of hiring a second pharmacist. Some pharmacies felt they were operating "at a loss" when delivering IP. One way to overcome the loss was by "squeezing" IP patients in between the pharmacist's other responsibilities and private clinics:

*The problem is that with the lack of funding currently in pharmacies at the moment, it's not sustainable for all [pharmacies to have two pharmacists] and if they're not getting enough services to warrant having a second pharmacist, then it's going to be quite tricky to implement nationally. ...There was a lot of resistance, I think, to the second pharmacist model on the basis of the current remuneration. I think it was widely seen that it wasn't essentially profitable to pay for these pharmacists... for a single pharmacist to come and run these sessions, or provide backfill, whatever, because they could essentially utilise that time more efficiently in the running of the broader business. So, I think that was a major issue.*  
(ICB senior pharmacy lead, ID62)

Some Pathfinder sites employed a locum pharmacist to cover some of the IP pharmacist's work to free up the IP pharmacist to deliver the IP service. Others employed foundation trainee pharmacists and supported further training for their pharmacy technicians and dispensers to be accuracy checking technicians (ACT) respectively:

*My skill mix is I've got two trainee pharmacists... what we did is trained up our dispenser to become an ACT... we could free up a lot of our pharmacist time by having an ACT. So, in the morning, one of us clinically checks the prescriptions and the trainee pharmacist will dispense them. And then the ACT will check it without us needing to be involved ever again. (...)* And that was how we created the capacity to be able to offer this. (IP pharmacist/pharmacy owner, ID74)

Without adequate skill mix and staffing, implementing IP could put a strain on the pharmacy team. Support staff would be expected to manage an increased workload, especially when a pharmacist was unavailable for an extended period:

*For us when we do that [deliver IP service] that puts more pressure on our team as well. ...our team doesn't gain much from what we're doing and instead it just puts more pressure on them...in being able to manage a lot of things without a pharmacist present... one example if I'm doing...a consultation and it took a bit longer than usual and someone wanting their prescription and then nobody can do that prescription but the pharmacist...., people will get frustrated and then,... take it [out] on them [pharmacy support staff] (IP pharmacist, ID36)*

Most Pathfinder sites operated with only one pharmacist who was responsible for all aspects of the business, including dispensing, checking, and managing the overall operation. When the IP pharmacist was the only pharmacist on site, this created logistical difficulties for scheduling clinics and providing a dedicated IP. Some IP pharmacists reported that their time was fragmented, as they were constantly pulled away to handle other pharmacy work. Having a wider skill mix meant that there was a need to ensure **a clear division of roles and responsibilities** to continue the delivery of core pharmacy work, even when the IP was occupied with a longer consultation. However, the viability of this model was claimed to be linked to the volume of prescriptions and number of customers.

Training and development were identified by our case study interviewees as important to support skill mix. Some pharmacies in Pathfinder sites had a proactive and long-term vision for their workforce, investing in training pharmacists to become independent prescribers and supporting their development as designated prescribing practitioners (DPPs) even before the

IP Pathfinder. They also invested in training pharmacy support staff to become pharmacy technicians and ACTs.

## Digital

The designated electronic prescribing solution for the Pathfinder programme was the nationally approved CLEO system, intended to operate as a standalone platform with integrated GP Connect access, which provided ‘view-only’ access to patient records. A lengthy delay in the rollout of CLEO led to some Pathfinders and ICBs developing workarounds where some Pathfinder sites went ahead without it, relying instead on established platforms like GP IT systems and traditional paper prescriptions to initiate their services. The use of a GP IT system such as EMIS or SystmOne allowed pharmacists to view a patient’s full medical history, order diagnostics such as blood tests, and write consultation notes directly into the patient’s record. Some Pathfinder sites relied on a combination of standalone systems. Alongside CLEO, PharmOutcomes was commonly used for the separate task of recording consultations. While familiar to pharmacy staff, the need to use a combination of different IT systems created a clunky and duplicated process. Moreover, it could delay the communication with GPs. Consultation notes were sent via NHSmail and could take a full day for someone at the GP practice to pick up the PDF and attached to the patient’s record, creating a clear information gap and a potential patient safety risk. Other systems played supplementary roles; for instance, Microsoft Teams was used for direct communication between pharmacists and GPs.

*The IT’s a massive challenge because I’ve got my laptop with EMIS and then I’ve got my desktop which I’ve got CLEO on and then what I end up doing is I end up typing it up in EMIS and then I copy and paste it into PharmOutcomes, and obviously I prescribe on CLEO and then I have to fill in this post evaluation consult. And so it just takes me ages... So I did drop typing up in EMIS because I thought, oh, I’ll just type up in PharmOutcomes but then I had a patient that had an adverse reaction to an antibiotic I gave, and then she represented at the surgery a little bit later and I’d gone home, and the GP couldn’t see my consult, so they couldn’t back up that I’d checked allergies, why I’d given the antibiotic and it just meant that that kind of blew up in our pharmacy, where the patient’s mum was, like, oh, my goodness, this pharmacist has given this antibiotic and it’s made my mum really poorly, she just had a bit of diarrhoea ... because the PharmOutcomes get sent to the GP NHS mail and that can take a day before that’s attached to the record. (IP pharmacist, ID38)*

Some interviewees questioned why Pathfinder sites had to use CLEO and could not use an existing GP IT system, such as SystmOne or EMIS, which were already enabled to do what was needed in clinical consultations such as viewing the patient’s past medical history (e.g. GP notes, clinical letters, blood tests), requesting bloods, booking patients for appointments, writing consultation notes, and generating EPS prescriptions. The alternative was to rely on the very limited information recorded in the summary care record (SCR). Some interviewees claimed that CLEO with access to national care records might work for purely walk-in services. However, they felt that for the management of long-term conditions like hypertension, lipids or HRT, a system which enabled a holistic view of the patient’s past medical history and collaboration with other providers would ensure the required collaborative approach to patient care:

*It [EMIS]’s more than just a transactional prescription [system], it’s note-taking, it’s history-taking, it’s understanding the wider picture of all the other tests and things. You definitely need the access to EMIS. And that creates the credibility, you know, this trust and credibility. If we’re using the same tools as them, they [the GP] can read everything we write and they can reply back to us and say you didn’t do this, you didn’t do that. ...that’s exactly what you want... the accountability and credibility and their ability to be able to have oversight... Patients feel the benefit because... I say to them straightaway; I’ve got access to your*

*records. ... it just gives us again credibility with the patient... knowing that I am obviously connected with the GP and I'm working with them and they haven't just been sent randomly to me (IP pharmacist/ pharmacy owner, ID74)*

The use of CLEO for issuing prescriptions was seen as adding an extra layer of complexity for those Pathfinder sites which also had access to the GP IT system. One pharmacist described an experience with a patient who had a complex urinary tract infection (UTI). After a thorough consultation and checking the patient's records, the pharmacist needed a quick check from the GP regarding a potential allergy before prescribing. Had this consultation taken place in a GP practice or a community pharmacy with read/write access to the GP record system, there would have been an easy-to-use internal messaging system to send a task or a quick text to the doctor for confirmation. However, since this IP pharmacist was working in a community pharmacy without this integrated system, they had to use a much more complex process, which involved filling out a separate form and sending it to the GP practice, resulting in a delayed response. This inefficiency complicated the process for everyone involved – the pharmacist, the GP who had to follow up the next day, and the patient, who had to wait longer for their prescription.

In addition to allowing IP pharmacists to have access to a full patient's record and hence providing a safer consultation, the use of existing GP IT systems was seen as a mechanism to build GPs' trust in the IP pharmacist's ability and confidence in delivering patient care which enabled collaborative working.

One of the biggest challenges in getting access to the GP IT system was related to data protection. However, some Pathfinder sites had overcome this by limiting the data sharing agreement to just one pharmacy and one GP practice, rather than pursuing a universal, hub-wide agreement with all GP practices in the area.

Most of the IP pharmacists we interviewed expressed frustration over having to use multiple platforms, which led to duplicated effort, manual data entry, and the potential for crucial information to be missed. The main concern for using multiple platforms was that IP pharmacists found it extended their consultation time. The safety concern cited was related to limited access to patient medical histories. IP pharmacists noted that although CLEO provided access to the patient's record via GP Connect, the limited access to patient medical histories in GP Connect was claimed to impact on IP pharmacists' ability to prescribe safely as they were unable to get a holistic view of the patient's health and medical history, or to access this directly with write access:

*There is a GP Connect as well which took time to arrive, but it was a little bit underwhelming. It's very unclear when using GP Connect when you're trying to look at a patient's past medical history. It's very difficult to interpret the way it's laid out and as I understand, there's no access to clinic letters or hospital discharge notes or anything like that. So, if you are prescribing, in my mind at least, there is a little bit of a concern for safety there. So, if I am prescribing something, I've not got any access to any recent changes or recent admissions at hospital or a particular clinic, so am I prescribing somewhat blindly? (IP pharmacist, ID110)*

Some of our interviewees suggested shifting the perception of viewing clinical data as a 'GP record' to seeing it as a 'patient record'. This change would grant all prescribing professionals, including pharmacists, equal access to the same information, which was seen as crucial for safely managing long-term conditions and would empower healthcare professionals within neighbourhood health teams to provide more holistic and safer care:

*I think what this Pathfinder Programme should show, is that it's not a GP record. We need to move nationally away from it being a GP record, it needs to be a patient record, so that everybody who's prescribing can have access to the same information. Otherwise, I mean, I know it's not so bad for minor ailments ... But if you're doing long-term conditions, you do*

*need that information. So that was a big barrier for me, is having information to clinical records, to be able to safely prescribe. (ICB pharmacy lead, ID3)*

### **Funding model**

The Pathfinder programme's funding was structured on a sessional basis, although the amount paid per session was specific to the Pathfinders and not itself being tested for future viability. There were mixed views in relation to this payment model.

Some Pathfinder sites were happy with this payment model. However, the sustainability of delivering IP was dependent on the number of patients being seen:

*I think it's fair whatever how many sessions is paid now. My only question is around...I do feel some of the sites will waste these resources mainly because you don't have a standard number of patients to be seen an hour or anything like that. And, indeed, it's community pharmacy, sometimes it's really difficult to predict because, ... even if we do have a rota in place, even if we do refer them actively from the practice to the community pharmacy we ... had a lot of them not attending those sessions, not attending that appointment in the community pharmacy mainly because I [patients] don't want to be sent to the community pharmacy. (Superintendent pharmacist, ID39)*

Others claimed that the sessional payment was misaligned with the actual workload required to deliver the service effectively. Our interviewees claimed that while the sessional payment covered consultations, consultation recordings, and clinical supervisions, there are other tasks such as chasing blood test results, managing appointments, and handling administrative claims, which were consistently performed outside of the paid sessions. This created a disconnect between the funding provided and the resources needed. However, from a commissioning perspective, the move to a sessional payment was viewed as a step towards a more outcome-focused model, rather than one based purely on activity volume.

The financial viability of the service was a primary concern for many Pathfinder sites. Some Pathfinder sites claimed that sessional funding often struggled to cover the full costs when there was a need to employ a second pharmacist or locum to backfill the IP pharmacist's other duties. This financial pressure was exacerbated by comparisons to other services; some interviewees noted that Pharmacy First was perceived as more profitable, with shorter consultations being remunerated at a higher rate and offering greater flexibility for pharmacists managing multiple roles, supported by an adequate skill mix.

A major challenge, particularly for models reliant on GP referrals, was the lack of sufficient and predictable patient volume. Without a consistent flow of referrals, the service could not generate enough revenue to enable it to become financially viable to invest in additional staff and fully embed the service. This unpredictability made business planning difficult and threatened the long-term sustainability of the model:

*There comes a tipping point, you have to have enough services coming through the door to be able to fund that, but once you get past that tipping point, yeah, the funding's then there, isn't it, for an additional member of staff to do that while the rest of business as usual carries on in the background? So that would be the ideal situation, in my opinion, for most places but unless you're getting sufficient services through the door to fund that then it's not possible." (ICB pharmacy lead, ID35)*

While some Pathfinder sites benefited from additional strategic investment from their parent company or the ICB, the core issue for many was that low referral numbers prevented the service from becoming profitable and self-sustaining in the future.

## Discussion

### Summary of findings

This summary of key findings will begin by describing the Pathfinder programme and what it was expected to achieve. Using insights from experiences of various stakeholders, we will explain how, why, to what extent, and in what contexts IP in community pharmacy works. Our analysis will focus on five key concepts crucial for successful IP delivery: clinical governance, supervision and support, skill mix, digital infrastructure, and funding.

NHS England launched the Community Pharmacy Independent Prescribing Pathfinder Programme to develop a framework for the future commissioning of NHS community pharmacy clinical services incorporating independent prescribing for patients in the community. NHS England's initial intention was to have 210 Pathfinder sites across all 42 Integrated Care Boards (ICBs). However, in practice, the number changed with some ICBs and Pathfinder sites de-registering. These models are broadly categorised into three areas: enhancing existing community pharmacy commissioned services such as acute minor illness and contraception; managing long-term conditions such as hypertension, lipid management, and respiratory disease; and introducing novel services including deprescribing, prescription management, and menopause services. The ICBs' site selection processes for the Pathfinder sites were extensive, focusing on the pharmacy's track record, operational readiness, and existing relationships within the primary care system. Pathfinder sites selected were usually high-performing pharmacies, often with strong pre-existing relationships with GP practices and a track record in delivering clinical services. Hence Pathfinder sites may not represent typical community pharmacies in England, many of which may lack the same resources and readiness.

The aim of this evaluation is to provide learning from Independent Prescribing (IP) in community pharmacy pathfinder sites. The evaluation describes what the programme has delivered and assessed the experiences of participating community pharmacies and other stakeholders to determine the future viability and sustainability of IP within community pharmacy and develop recommendations to inform the future direction of the commissioning and implementation of IP in community pharmacy.

We developed initial programme theories from key informant interviews and analysis of expressions of interest. We tested and revised these theories using the data we gathered for the evaluation. Following the overall synthesis of findings from combined data sources (interviews and case studies), the final programme theory comprised 38 Context-Mechanism-Outcome Configurations (CMOCs) and is outlined in Appendix 3.

In the context of a minor illness model, the initial programme theory was that a close working relationship between community pharmacists and GPs was expected to lead to better collaboration at the neighbourhood level, a high referral rate, and enable the use of existing infrastructure already built from Pharmacy First/CPCS (Community Pharmacist Consultation Service) minor illness. However, a close working relationship may not necessarily be needed for walk-in models.

Our evaluation revealed granular differences in the delivery of the minor illness model in practice, depending on whether it was a walk-in model or one that relied on GP referrals or referrals from other pharmacies. The **minor illness walk-in model** was seen as an extension of Pharmacy First, which was delivered using existing processes and infrastructure and an expanded scope of practice. However, there were operational challenges, such as how to record for payment when a patient came in for Pharmacy First, but following consultation, it was identified that the patient could be seen under IP. However, more importantly, from a commissioning perspective, it was difficult to decide how to distinguish IP from services that did not require pharmacists to be an IP.

For the **minor illness model that relied on GP referrals**, Pathfinder sites developed a close working relationship with GPs and GP practice staff, which was needed for sufficient numbers and appropriate referrals, as well as clinical support on the day and escalation. In Pathfinder sites where there were no existing relationships between community pharmacists and GPs, the Regional Senior Integration Pharmacy Leads (RSPILs), Community Pharmacy Clinical Leads (CPCLs) and others with similar roles were found to be instrumental in facilitating the relationship and trust building.

For the **minor illness model that received referral from neighbouring pharmacies**, which involved another pharmacy referring patients to Pathfinder sites, this was viewed as strengthening the collaborative relationship between community pharmacies rather than being in competition with each other. A potential drawback was that patients might not be able to be seen at their nominated pharmacy, potentially requiring them to travel to another pharmacy.

The initial programme theory for **delivering long-term conditions models, lipid management, or novel services** was that these models required a ‘joint partner’ approach, where both GPs and community pharmacists engaged in proactive, shared decision-making. This was expected to enable coordinated care for patients with chronic conditions who are relatively stable to be managed at community pharmacies. Community pharmacists would be seen as independent practitioners with accountability and shared ownership in decision-making with GPs, rather than being regarded as an extension of the GP’s team.

Our evaluation shows that achieving a ‘joint partner’ model required building trust and relationships between community pharmacists and GPs to enable IP pharmacists to be accountable and independent practitioners in the safe and effective management of these models. This joint partner approach relied on the trust and relationships between IP pharmacists and GPs. For example, trust was built when GPs had positive experiences with the IP pharmacists’ clinical judgment and safe prescribing. Pharmacists’ confidence-building often went hand in hand with GPs’ increasing trust, sometimes built over time through a phased introduction to new services where GP input (and clinical supervision) was greatest at the start, and which allowed IPs to gradually build their scope of practice. This worked well where community pharmacies and GP practices had managed to connect their IT systems and access to patient records. However, the lack of interoperability between different IT systems meant different system had to be used for different purposes and an inability (unless using the GP’s own system) to add notes to patient records in real time. This caused delayed sharing of care information and hence fragmented care, increased workloads in community pharmacy and general practice, longer consultation times, and raised concerns about patient safety.

Implementation of the models described above was dependent on five key concepts: clinical governance, supervision and support, skill mix, digital infrastructure, and funding. Below we use these key concepts to synthesise the experiences of IP pharmacists, employers/owners, GPs, and other stakeholders in the Pathfinder programme.

**Clinical governance:** The initial programme theory was that by giving ICBs a high degree of flexibility in designing their own local governance, this would generate valuable insights into different governance models and identify what worked (or not) in diverse contexts. Establishing robust clinical governance for the novel IP service was a complex process, aided by varied approaches adopted by ICBs. The inexperience of many community pharmacies, particularly independent pharmacies, in creating necessary documentation like SOPs and risk assessments was a significant hurdle. Most ICBs adopted a highly supportive, ‘hand-holding’ approach, with dedicated staff meticulously guiding sites through extensive assurance processes to build strong relationships and ensure compliance. A smaller number of ICBs took a more traditional commissioning stance, setting clear standards in a Service Level Agreement (SLA) while making it the provider’s explicit responsibility to develop their own tailored processes, supporting them with templates and collaborative peer groups rather than direct

intervention. Key governance risks, such as the potential conflict of interest between prescribing and dispensing and the difficulties in securing clear indemnity insurance for a new service, were consistently identified. These governance risks were managed through a combination of mandatory SOPs to separate roles and proactive self-audits. Although often burdensome, pharmacists felt the need to conduct these self-audits because the available indemnity options were vague, costly, and left them feeling exposed.

**Supervision and support:** The initial programme theory envisaged that IP pharmacists would need to be provided with clinical supervision and support to ensure safe and coordinated care. Our evaluation found a variety of supervision and support mechanisms that were implemented in practice. There was formal clinical supervision, such as regular one-to-one sessions provided by a GP, a PCN pharmacist, or external provider. There were also more informal peer support networks like virtual meetings and WhatsApp groups. These mechanisms were found to be crucial for building IP pharmacists' competence and confidence, particularly in new clinical areas, and for improving patient safety through case reviews and direct access to duty doctors for urgent on-the-day advice. It was also found to build GPs' trust in IP pharmacists. However, formal supervision by GPs was found to place an additional and often uncompensated workload on GPs. Other studies have shown that, due to community pharmacists often working in isolation, and the importance of IP pharmacists needing to be supported to build their competence and confidence, remote educational supervisors could provide some of the required supervision and support needed by IP pharmacists<sup>6,7</sup>.

**Skill mix:** The initial programme theory behind skill mix was that Pathfinder sites were expected to utilise the skills of the wider pharmacy team to enable IP pharmacists to focus on IP clinics. Our evaluation found that training and development were an important mechanism to support appropriate skill mix of the wider pharmacy team. Pharmacies with a proactive and long-term vision for their workforce had invested in training pharmacists to become independent prescribers before the Pathfinder programme, and they supported their IP pharmacists' development as DPPs. This also included training pharmacy apprentices to become pharmacy technicians and ACTs. Our evaluation shows that in Pathfinder sites where they had established the skill mix and structure for delegating tasks to other pharmacy team members, this was found to free up IP pharmacists to focus on delivering IP. Other Pathfinder pharmacies employed a second pharmacist to manage the extra demand and workload in the pharmacy<sup>8,9</sup>. There was a concern among some IPs that upskilling pharmacy technicians might lead to them leaving to work in primary care and hospitals due to frustrations with pay and responsibilities in community pharmacies. A critical challenge is the growing disparity between pharmacy technicians' increasing responsibilities and the sector's comparatively low salaries, which creates significant issues for workforce morale, recruitment, and retention<sup>10</sup>.

**Digital:** The initial programme theory envisaged that the use of an independent electronic prescribing solution (EPS) called CLEO would enable IP pharmacists to be seen as independent practitioners rather than as an extension of the GP's team. Moreover, while access to individual GP practices' IT systems might work for independent pharmacies or pharmacies which interacted with a very small number of GP practices, it would create challenges for chain pharmacies. Our evaluation shows that the digital infrastructure for the Pathfinder programme created significant challenges such as the time and effort spent, such as using the GP IT system alongside CLEO. The nationally designated prescribing system, CLEO, was a standalone platform with limited 'view-only' access to patient records via GP Connect. Pharmacists found this system inadequate for managing complex or long-term conditions because it lacked access to crucial information like hospital discharge notes and did not support seamless communication with GPs. Some Pathfinder sites found workarounds with direct access to GP IT systems and patient notes, which facilitated better communication and more integrated care. The use of different IT systems, however, could lead to duplication of effort and delays. According to our interviewees, a well-functioning IT system that supports seamless patient care was one that provides direct, real-time, read/write access to a single,

unified patient record to enable seamless collaboration through built-in communication tools for quick and accountable interactions between IP pharmacists and GPs, while also creating a transparent and auditable trail of all actions to foster trust and accountability.

**Funding:** The initial programme theory behind the funding for the Pathfinder programme was for Pathfinder sites to receive significant pump-priming funding from NHS England for setup costs, digital solutions, and sessional payments for various activities (including supervision) with the long-term goal for IP to become 'business as usual' within existing funding. Our evaluation found that, from a commissioning perspective, the sessional payment model was regarded as a positive step towards paying for outcomes achieved. From the perspectives of employers/owners and IP pharmacists, community pharmacies as private businesses needing to be profitable was a necessary consideration for them to continue offering IP services. Furthermore, funding needed to be predictable (with some time required for planning) and sustainable, so that investment in staff, infrastructure etc. could be justified. Participation in the Pathfinder was found to sometimes cost more than the funding provided, according to community pharmacy interviewees. Pathfinder programme funding included the provision of clinical supervision for IP pharmacists, which was viewed as very important (see preceding sections). However, our participants questioned the sustainability of this model as rolled out under the Pathfinder programme, with less funding likely to be available for infrastructure building and the setup and supervision costs arising from the transition of clinical services from GP practices to community pharmacy.

The final programme theories can be found [here](#).

## Strengths and limitations

The strength of the evaluation lies in its qualitative approach, which provided an in-depth understanding of the Pathfinder programme from the perspective of various stakeholders. We conducted a substantial number of interviews (n=141), significantly exceeding our initial target of 60. This was a direct result of the Pathfinder sites' strong enthusiasm to participate in the evaluation. The use of case studies enabled the evaluation to capture nuanced experiences and in-depth insights from the Pathfinder sites. We expanded insights further by also seeking the views of those who did not participate or had withdrawn from the Pathfinder programme. This allowed for a detailed exploration of how the Programme works (or not), in what context, and why.

The evaluation has some limitations. The absence of quantitative analysis, such as the number of patients treated or the frequency of prescribing, prevented a fuller assessment of the programme's outcomes. Patient experiences were not within the remit of the evaluation. However, during interviews, we gathered some views from interviewed IP pharmacists as well as surveys of patient views conducted locally, by Pathfinder sites or ICBs. Lastly, most of the participating sites were independent pharmacies rather than larger chains. However, we managed to conduct a number of interviews with representatives from chain pharmacies, to ensure we gather views from all relevant stakeholders to inform recommendations which can be relevant across the sector.

## Actionable messages

We presented our findings to an online stakeholder event involving 67 participants, drawn from IP pharmacists, ICBs, PCNs, community pharmacy employers and representative bodies. We used this event to sense check our findings and recommendations through discussion with participants. This has led to the following 'actionable messages' which we have grouped under the key stakeholders and decision-makers most likely to be able to implement them.

## NHS England/DHSC

- To develop a national governance framework that sets standards to ensure patient safety. This framework should:
  - Define the responsibilities for each stakeholder group, including NHS England/DHSC, ICBs, IP pharmacists, and employers.
  - Allow some flexibility at regional/ neighbourhood level to meet local needs and allow for the development of innovative models of care that can be tailored to local populations.
  - Set a clear and standardised understanding of indemnity and the scope and risks involved in delivering IP in community pharmacy.
  - Set clear expectations around training, continuing professional development, support, and supervision for all IP pharmacists, particularly Newly Qualified Pharmacists (NQP) or those transitioning to IP roles.
  - Acknowledge that supervision and support for IP pharmacists need to be tailored to the pharmacists' specific needs and that elements of this could be provided by external organisations to minimise the burden on existing staff.
  - Guide the community pharmacy sector, and provide incentives for adapting the skills mix in community pharmacies to enable the delivery of IP at scale.
- To recognise that community pharmacies are businesses that require long-term, sustainable business models to continue delivering high-quality patient services. This requires:
  - Ensuring enough funding and sustainability to allow employers to invest in their workforce.
  - Setting a direction of travel that includes the sustainable and consistent flow of new services and clinical activity into community pharmacy, which will enable both local commissioners and contractors to invest in infrastructure and upskilling staff.
- To develop a national strategy for robust infrastructure, essential training, and ongoing clinical supervision and support to drive the fundamental behaviour change required for IP pharmacists to work safely and effectively within the wider healthcare system. This requires:
  - Access to patient records that enable IP pharmacists to not only view patients' medical histories for safe prescribing, but to directly communicate with GP practices.
  - Access/ infrastructure to diagnostics such as phlebotomy, recognising it as a key element of future clinical services.
  - A clear and robust framework for delegating authority within the pharmacy team, in particular to pharmacy technicians.
  - Clinical note-taking to be part of IP practice.
- To implement change incrementally, which will enable:
  - Behavioural and cultural shifts.
  - IP pharmacists to build their confidence in delivering IP.
  - The wider healthcare and neighbourhood team to gain confidence in community pharmacy as collaborative partners in patient care.
- To implement monitoring at the national level to ensure that prescribing practices align with national expectations and so that patient feedback is gathered systematically to enable continuous improvement at the pharmacy and ICB level.
- To acknowledge the significant scale of this paradigm shift and cultural change and commitment to a substantial, sustained investment in workforce development and behavioural change initiatives across both community pharmacy and its partners in neighbourhood health systems.

## ICBs/Neighbourhoods

- To adapt services to meet local needs while ensuring equitable delivery of IP and access to supervision and support for IP pharmacists. While NHSE/DHSC set the national framework, there should be sufficient flexibility for the processes to be managed locally, either at the ICB or the Neighbourhood level. To provide system-level oversight for broader safety and quality assurance by:
  - Collecting and monitoring consultation and prescribing data and patterns across the locality to understand how prescribing practices align with local health needs and commissioning intentions, ensuring services are safe, effective, and responsive to the community.
  - Collecting patient feedback systematically.
- To facilitate access to supervision and support for IP pharmacists, essential diagnostic services like phlebotomy and pathology, and provide support for IT integration under a clear set of nationally set expectations/framework. This requires:
  - Local leaders to represent community pharmacy at the neighbourhood level. This role is crucial for sharing best practices and aligning services.
  - Continued funding for dedicated integration leads such as RSPILs and CPCLs to serve as the essential link between ICBs/Neighbourhoods and frontline pharmacy providers. These roles will manage system alignment, facilitate communication, and act as the designated point of contact for integration.
  - Funding for IP pharmacists to have protected time away from their day-to-day duties. This is essential for them to attend neighbourhood-level or PCN meetings and build local relationships.
- To ensure that the principle of fairness and equitable access must be a key consideration when implementing local variations under a national framework in the delivery of IP. While neighbourhood teams may tailor services to local needs, all commissioning decisions must actively support a patient's right to choose their preferred pharmacy setting in which to receive care as sometimes the choice is between being treated by a GP or in community pharmacy and guarantee a consistent standard of care across the locality and nationally.

## Employers

- To utilise the impending change in supervision legislation to free pharmacists from dispensing duties, enabling them to assume more clinical responsibilities. This requires a guided strategy and flexible implementation to support different teams and individuals.
- To implement the skill mix needed in community pharmacy to deliver IP and help individual pharmacies implement this in practice.
- To facilitate and ensure that investments in infrastructure are made to meet the needs of patients and establishing clinical services in community pharmacies at scale.
- To be responsible for securing appropriate corporate or group indemnity that explicitly covers the full scope of IP services delivered by their employees.

## Individual pharmacists (including IPs)

- To build trust within pharmacy teams to enable IP pharmacists to focus on delivering IP. This can be done by:
  - Having a well-supported and empowered team, with clear roles and responsibilities for each member of the team.
- To deliver safe, high-quality patient care, individual IP pharmacists must be professionally accountable for their practice. This includes understanding their indemnity cover, working within their scope of practice, and following all governance procedures.

## References

1. NHS England. Fit for the Future: 10 Year Health Plan for England, <https://www.england.nhs.uk/long-term-plan/> (2025, accessed 29 September 2025).
2. NHS England. *Community Pharmacy Workforce Survey 2024*, <https://www.hee.nhs.uk/sites/default/files/documents/Community%20Pharmacy%20Workforce%20Survey%202024%20Key%20findings.pdf> (2024).
3. General Pharmaceutical Council. GPhC registers data, <https://www.pharmacyregulation.org/about-us/publications-and-insights/research-data-and-insights/gphc-registers-data> (accessed 25 February 2025).
4. NHS England. Independent prescribing, <https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-integration-fund/independent-prescribing/> (accessed 26 January 2024).
5. Better Evaluation. Realist evaluation, <https://www.betterevaluation.org/methods-approaches/realist-evaluation> (2024, accessed 25 September 2025).
6. Styles M, Schafheutle E, Willis S, et al. Pharmacy professionals' perceptions of educational supervision in primary care through the lens of Proctor's model. *BMC Med Educ* 2023; 23: 503.
7. Styles M, Middleton H, Schafheutle E, et al. Educational supervision to support pharmacy professionals' learning and practice of advanced roles. *Int J Clin Pharm* 2022; 44: 781–786.
8. Bradley F, Willis SC, Noyce PR, et al. Restructuring supervision and reconfiguration of skill mix in community pharmacy: Classification of perceived safety and risk. *Research in Social and Administrative Pharmacy* 2016; 12: 733–746.
9. Bradley F, Schafheutle EI, Willis SC, et al. Changes to supervision in community pharmacy: pharmacist and pharmacy support staff views. *Health & social care in the community* 2013; 21: 644–654.
10. McDermott I, Willis S, Hindi A, et al. *Research to understand what motivates people to choose a career as a pharmacy technician and what factors contribute to pharmacy technician attrition from the General Pharmaceutical Council Register: Final report*. University of Manchester, November 2023.

## Appendix 1: Case study characteristics

Characteristics	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8	Site 9	Site 10
Clinical model	Minor illness (Pharmacy First)	Mental health and expanded to deprescribing	Minor illness	Hypertension, lipid management, and HRT	Extended minor illness (Pharmacy First Plus), hypertension, and contraception	Minor illness	Minor illness and respiratory	Hypertension and lipid management	Minor illness	Minor illness, CVD, and lipid management
Implementation	Referrals through PCN: SHP through the Pharmacy First portal, walk-ins, NHS 111 and word of mouth	Referrals from the GP practice	Referrals from two GP practices for conditions outside the scope of Pharmacy First, such as simple chest infections	Referrals from a linked GP practice	Referrals from several GPs in the area	Referrals from a GP practice but patients can also be identified through an ad-hoc consultation with the IP pharmacist	Referrals from 2 GP practices and walk-ins	Referrals from the GP practice based on searches conducted by the IP pharmacist themselves	GP referrals, walk-ins, and online bookings	GP referrals, internal referrals (from Pharmacy First)
IP clinics			The site runs a half-day IP clinic every weekday from 1:00 PM to 5:00 PM, with half-hour appointment slots	Two four-hour-long sessions per week		Four days a week with sessions in the morning and afternoon	Three days per week – on Mondays, Tuesdays and Fridays, as the funding only allows for a limited number of sessions, and it's financially demanding to have a locum pharmacist or checker every day.	Three four-hour-long IP Pathfinder sessions per week	Independent prescribing is offered all day every day, except Tuesdays and Saturdays, with appointments running from 9:30 to 1:00 and 2:30 to 5:30, one every 15 minutes.	IP is offered Monday-Thursday with Fridays functioning as an admin day
Pharmacy type	Independent	Independent	Independent	Independent	Independent	Small chain	Large chain	Independent	Independent	Independent

Space (number of consultation rooms)	2 consultation rooms	2 consultation rooms	2 consultation rooms – one dedicated to IP.	2 – resulting from the recent decision to divide one consultation room into two. One of them not yet fully equipped and fitted	2 consultation rooms – one room was the main consultation room and reserved for pre-booked appointments, including IP.	1 consultation room (including for IP) and a consultation space, which will be converted into a consultation room if the IP Pathfinder was extended and made more profitable.	3 consultation rooms, one of which was purpose-built for delivering IP.	2 consultation rooms, the pharmacy recently refurbished to drastically reduce the shop floor space and make space for the consultation rooms.	1 small consultation room, with plans to add more consultation rooms in the next refit.	3 consultation rooms, with one dedicated to IP. The pharmacy underwent a comprehensive refit prior to the start of the Pathfinder.
Pharmacy location	This site is in a relatively less deprived area. It's in the least deprived 30% of England (IMD Decile 8).	This site is in one of the most deprived in England (IMD Decile 1). It faces significant challenges, including very high levels of income and education deprivation.	This site is among the most deprived 20% in England (IMD Decile 2).	This site is in an extremely affluent area, ranking among the least deprived 10% in England (IMD Decile 10).	This site is in an area that is moderately well-off, falling into the least deprived 30-40% of England (IMD Decile 7).	This site is in an exceptionally deprived area, ranking among the most deprived 10% in England (IMD Decile 1). It faces extreme levels of deprivation across multiple factors.	This site is in a deprived area, ranking in the most deprived 20% of England (IMD Decile 2).	This site is in a deprived area, ranking in the most deprived 30% of England (IMD Decile 3). It faces significant income deprivation and a very high crime rate.	This site is in a very well-off area, ranking in the least deprived 20% of England (IMD Decile 9).	
Digital	CLEO and PharmOutcomes	EMIS, PharmOutcomes, Cegedim Rx and AccuRx	CLEO and PharmOutcomes, a booking dashboard that provides a real-time view of the	EMIS, CLEO	CLEO, Google form, SystemOne, PharmOutcomes	CLEO, PharmOutcomes	Local shared care records, CLEO and PharmOutcomes	EMIS, pharmacy dispensing software (to send texts to patients)	CLEO, local shared care records, PharmOutcomes, NHSMail, AccuRx	EMIS, CLEO and PharmOutcomes

			pharmacy's appointments							
Pharmacist on site	1 IP pharmacist was also the superintendent. They had a locum pharmacist on Pathfinder days.	1 IP pharmacist was the superintendent Pharmacist and also the owner. They had a locum pharmacist on Pathfinder days.	2 part-time IP pharmacists and a regular locum pharmacist who oversees dispensing, delivers Pharmacy First and ad-hoc consultations.	1 IP pharmacist who was also an owner, director. A locum pharmacist sometimes comes to help out in replacing the IP for accuracy checking around two times a week.	2 pharmacists (1 IP pharmacist)	2 IP pharmacist, one of them was the superintendent. Another pharmacist (not yet registered with GPhC) will soon start and will be delivering the Pathfinder service once a week under the supervision of current IP.	1 IP pharmacist who was also the pharmacy manager and 1 regular locum pharmacist employed 2 days per week. The IP pharmacist was the only checker at the time, and was also supervising an apprentice pharmacist.	1 IP pharmacist and 1-2 other pharmacists, one of which is the co-owner.	1 IP pharmacist.	2 IP pharmacists, and a third pharmacist who worked on Fridays. Only one IP delivers the IP Pathfinder FT and was more highly trained/skilled than the second IP who delivered Pharmacy First and is the pharmacy manager.
Skill mix	1 pre-registration trainee pharmacist, 1 pharmacy technician, and 1 trainee pharmacy technician.	2 pharmacy technicians, one of them accuracy checking, one trainee pharmacy technician, 1 dispensing assistant, 1 medicine counter assistant	2 accuracy checkers, 2-4 dispensers, 1 – pre-registration trainee pharmacist 3 times per week, 3 support staff at the counter	4 dispensers, one works full-time and lead the other dispensers while also being responsible for services such as earwax removal and booking patients in.	3 dispensers, one of which training to become ACT, 1 dispensary trainee / counter assistant.	3 counter staff (Level 2), 1 dispenser, 1 dispensing manager who was in the process of qualifying as ACT, 1 dispenser overseeing medication for delivery.	1 dispenser who was also in the process of ACT qualification, 2 pharmacy assistants who were Level 2 dispensers.	2-3 ACTs , 6-7 apprentices-dispensers and 2 pharmacy assistants.	2 accuracy checking technicians, 3 dispensers, 1 front-of-house staff.	1 foundation trainee pharmacist, 2 ACTs, 5 dispensers, 1 counter assistant.

## Appendix 2: Initial Programme Theories

**CMOC1 (clinical model):** In the context of a minor illness model that received GP referrals, the theory was that a close working relationship between community pharmacists and GPs was expected to lead to better collaboration at the neighbourhood level, a high referral rate, and enable the use of existing infrastructure already built from Pharmacy First/CPCS (Community Pharmacist Consultation Service) minor illness. However, a close working relationship may not necessarily be needed for walk-in models.

**CMOC2 (clinical model):** Implementing long-term conditions model or novel services requires a "joint partner" approach, where both GPs and community pharmacists engage in proactive, shared decision-making. This requires joint access to medical records, pathology requests, and interpretation. This would enable coordinated care for patients with chronic conditions who are relatively stable to be managed at community pharmacies. Community pharmacists would be seen as independent practitioners with accountability and shared ownership in decision-making with GPs, rather than being seen as an extension of the GP's team.

**CMOC4 (clinical supervision and support):** IP pharmacists need to be provided with clinical supervision and support to ensure safe and coordinated care.

**CMOC5 (skill mix):** Pathfinder sites were expected to utilise the skill mix in the wider pharmacy team to enable IP pharmacists to focus on IP clinics.

**CMOC6 (digital):** The use of an independent electronic prescribing solution (EPS) called CLEO was expected to enable IP pharmacists to be seen as an independent practitioner rather than as an extension of the GP's team. Moreover, while access to the GP IT system might work for independent pharmacies, it would create challenges for chain pharmacies.

**CMOC7 (funding):** The Pathfinder programme received significant pump-priming funding for setup costs, digital solutions, and sessional payments for various activities (including supervision), with the long-term goal of IP becoming "business as usual" within existing funding.

## Appendix 3: Context-Mechanism-Outcome Configuration (CMOCs)

CMOCs	Contexts	Mechanisms	Outcomes
CMOC1	Existing community pharmacy commissioned services.	Pharmacists already have experience with CPCS (Community Pharmacist Consultation Service) and Pharmacy First.	Quicker implementation of IP.
CMOC2	Models that deal with non-complex patients.	To build pharmacists' confidence and experience.	In the long run, to deliver more novel services, complex patients, and ultimately deal with newly diagnosed patients. However, more complex patient would still require management by a GP.

CMOC3	Minor illness referral from GP practice.	<ul style="list-style-type: none"> <li>• Requires buy-in from and agreed local processes with the GP practice.</li> <li>• Requires GP practice understanding of what can be treated in CP and what not</li> <li>• Requires creating a triage system in GP practice for referral to IP Pathfinder.</li> </ul>	If it works: appropriate referral and management in CP Unintended consequences: Increase in GP practices' and pharmacists' workload.
CMOC4	Enhanced Pharmacy First	Pharmacy First minor illness services (referral from GP practices) operated with a strict set of inclusion and exclusion criteria. This resulted in some patients being referred by their GP practice only to be sent back, which led to frustration for both patients and the GP practice.	The pathfinder site can identify the patients who had been sent outside of the Pharmacy First service within the independent prescribing competence, then reviewed the patients and offered them a consultation.
CMOC5	Long-term conditions and novel services.	Close collaboration with local GP practices.	<ul style="list-style-type: none"> <li>• GP buy-in and acceptance.</li> <li>• Implementation of IP without causing unnecessary increase in workload for the GP practice.</li> </ul>
CMOC6		Implement strict inclusion criteria initially.	<ul style="list-style-type: none"> <li>• Build experience and confidence within the service.</li> <li>• Expanding its scope and patient eligibility while ensuring safe and effective rollout.</li> </ul>
CMOC7		IP pharmacist's and GP practice staff's (understanding of and support for, as well as) proactive approach in informing patients about the service.	Patients are more likely to use the service in the future.

CMOC8		IP pharmacists' lack of confidence in interpreting blood test results. This requires paradigm shift and time and practice for IP pharmacists to build their confidence.	<ul style="list-style-type: none"> <li>• GPs reviewing blood test results.</li> <li>• GPs trained the IP pharmacists, which increased their workload initially.</li> </ul>
CMOC9		Lack of necessary infrastructure (e.g. access to pathology)	<ul style="list-style-type: none"> <li>• ICBs fund local pathology labs for development work to provide an interim solution.</li> <li>• Having a data sharing agreement for IP pharmacist to have access to the existing GP IT system.</li> </ul>
CMOC10	Integrating lipid management, hypertension management, and atrial fibrillation screening into a comprehensive package.	Phased implementation approach.	Manageable development and integration stages.
CMOC11	Delivery of IP	Requires collaboration between IP pharmacists and their local GP practice.	Holistic patient care
CMOC12	In a region with a large, diverse regional area and multiple ICBs.	<ul style="list-style-type: none"> <li>• A proactive Regional Senior Pharmacy Integration Lead (RSPIL) actively facilitating this inter-ICB collaboration, ensuring communication and alignment.</li> <li>• Requires digital platforms to support standardised processes and information sharing</li> </ul>	Reduction in duplication of commissioning and development efforts across the region, leading to a more streamlined commissioning process and potentially enabling more consistent (though locally adaptable) delivery of IP where appropriate.

		between ICBs across the region.	
CMOC13	In a region with a large number of Places/ Neighbourhoods within an ICB.	The ICB selectively commissioned IP in a small, pre-determined number. This selection was based on criteria such as the type of GP practices served or patient demographics/ health needs.	<ul style="list-style-type: none"> <li>• Allowing for easier steering and more focused engagement with local stakeholders in a Neighbourhood.</li> <li>• Allowing community pharmacies within a Neighbourhood to collaborate, hence minimising the feeling of isolation.</li> </ul>
CMOC14	Community pharmacy with a single IP pharmacist and for those with limited prior experience of providing IP.	Requires ICBs to hand-hold community pharmacies and guide them through the governance process.	IP pharmacists feel more empowered, supported and confident in establishing their clinical governance for IP in their pharmacy.
CMOC15	Consolidation of prescribing policies for all non-medical prescribers into one policy.	Having ICB staff with historical knowledge of the local commissioning framework and its policies facilitates this process.	A more streamlined governance framework for all non-medical prescribers (e.g. on incident reporting) and analysis of prescribing data (for GPs and other non-medical prescribers such as nurses).
CMOC16	ICB's role is to provide guidance and not write Standard Operating Procedures (SOPs) or protocols.	<p>Relies on professional accountability, where independent prescribers prove their competence through registration, continued professional development (CPD), and adherence to established guidelines (NICE, local formulary).</p> <p>Relies on community pharmacies working closely with GP practices to develop protocols about how they would work together and who should be doing what.</p>	Places professional responsibility on IP pharmacists and operational processes in pharmacies under an overarching national framework.

CMOC17	Conflict of interest with IP pharmacist having a dual role as a prescriber and a dispenser.	The need to have a second pharmacist to double/triple-check patients' medical history, allergies, and medications.	There were challenges in ensuring conflict of interest was managed appropriately, medications were dispensed safely, and clinical checks were performed adequately. However, having two pharmacists were seen as unsustainable.
CMOC18	Indemnity cover was the responsibility of the IP pharmacists	Insurance companies lack familiarity with this specific new service and its associated risks.	Refusal to provide cover, or the provision of incomplete or unsuitable coverage. Employer endurance means limited to certain sites
CMOC19	Lack of a nationally standardised framework for indemnity and competence.	IP pharmacists, driven by professional responsibility and a desire for accountability, resorted to self-imposed internal audits.	Individual IP pharmacists feel more secure and accountable, but this was recognised as unsustainable and may act as a significant factor inhibiting IP pharmacists from delivering IP.
CMOC20	Ability to deliver IP across the wider healthcare system.	The significant financial disparity between the employer's group indemnity and the individual's personal indemnity forces the IP pharmacist to make a cost-driven decision.	The IP pharmacist's professional mobility will be restricted as they would be unable to use their IP qualification in other settings/ branches, as their insurance coverage is tied to a single location. This prevents the wider utilisation of their IP skills across the healthcare system.
CMOC21	One-to-one clinical supervision provided by a GP or an IP pharmacist working at the GP practice.	<ul style="list-style-type: none"> <li>• Having an allocated clinical supervisor who can meet regularly (in-person, online or through messages) to discuss cases.</li> <li>• IP pharmacists could spend some time at the GP practice, shadowing the GP or the IP</li> </ul>	<ul style="list-style-type: none"> <li>• Increase pharmacist confidence.</li> <li>• If supervised by a GP, this can increase GPs' confidence and trust in IP pharmacists. But this has an unintended consequence of increasing the GP workload.</li> </ul>

		pharmacist working at the GP practice.	
CMOC22	Group supervision provided by a GP.	Organised by the ICB for the IP pharmacists in the local region/Neighbourhood.	<ul style="list-style-type: none"> <li>• Increase in pharmacist confidence.</li> <li>• Increase in GP's confidence and trust in IP pharmacists.</li> <li>• Possibly reducing workload on local GPs.</li> </ul>
CMOC23	Clinical supervision provided by a private healthcare provider	Group supervision or supervision on a limited time basis, depending on funding availability.	<ul style="list-style-type: none"> <li>• IP pharmacist received some form of support - a group-based, regional supervision model, which was perceived as far less valuable than the one-to-one arrangements with local GP practices.</li> <li>• Issues with sharing of confidential patient information and accountability.</li> </ul>
CMOC24	Clinical support	Direct access to the duty doctor at the local GP practice.	<ul style="list-style-type: none"> <li>• Can get immediate advice about patients or escalate patients if needed.</li> </ul>
CMOC25	Peer support network	Informal support network using WhatsApp.	Advice from a peer rather than the patient's GP, which can have an impact on patient safety.
CMOC26	Expanding the skill mix of the pharmacy team	<ul style="list-style-type: none"> <li>• Good skill mix with clear roles and responsibilities.</li> <li>• A bigger space and more consultation rooms.</li> <li>• Staff to be supported with training and development.</li> <li>• The need to have enough services to support the skill mix.</li> </ul>	Delivery of IP alongside other clinical services (e.g. Pharmacy First) while maintaining other pharmacy businesses.
CMOC27	Collaboration between ICB and	Having a Senior Pharmacist in post	<ul style="list-style-type: none"> <li>• Provides senior leadership.</li> </ul>

	other stakeholders within the system		<ul style="list-style-type: none"> <li>• Facilitates stakeholder buy-in.</li> <li>• Provides oversight and guidance to Community Pharmacy Clinical Leads (CPCLs).</li> <li>• Facilitates strategic decision-making processes and stakeholder engagement.</li> </ul>
CMOC28	Collaboration between ICBs	The importance of RSPIL	<ul style="list-style-type: none"> <li>• Facilitates collaboration between the various ICBs in the region.</li> <li>• Coordinates efforts and initiatives across the ICB footprint.</li> <li>• Enabling peer-to-peer learning by connecting CPCLs from different ICBs.</li> </ul>
CMOC29	Delay in the national roll-out of the Pathfinder IT system	Pre-existing relationship with local GP practice.	<ul style="list-style-type: none"> <li>• IP pharmacists having access to GP IT system</li> <li>• IP pharmacists delivering the service from the GP practice.</li> </ul>
CMOC30	Integration/ collaboration	IP pharmacist working across different settings (in a community pharmacy and a local GP practice)	GP blocked their clinic once a week to discuss any queries that IP pharmacists have (patients/services). The IP pharmacist can also contact the duty doctor at the GP practice for any queries on the day.
CMOC31	Collaboration between the IP pharmacist and the GP practice	Working with the PCN pharmacy team, as they could be more available than the GPs and have a better understanding of the potential of community pharmacy in delivering IP.	Potentially reducing the need to add to the GP workload.

CMOC32	Where there is no existing relationship between the community pharmacy and a local GP practice.	Requires a dedicated support (e.g. through an ICB Pharmacist) to facilitate meetings and communication.	Better understanding and working/ collaboration.
CMOC33	Doubt over IP pharmacists' ability.	Lack of understanding of IP pharmacists' training, skills and competence.	Ensuring that there is clinical support and supervision for individual prescribers who often work in isolation. Need to build GP trust gradually
CMOC34	Limited consultation room	New appointments need to be slotted in around other clinical services and follow-up appointments need to be scheduled.	Limits the ability to provide regular and consistent IP.
CMOC35	Using the existing GP IT system	<ul style="list-style-type: none"> <li>• Access full patient records (e.g. blood tests, clinic letters)</li> <li>• Shows adherence to clinical standards.</li> <li>• GPs can view a pharmacist's entire consultation, notes, and recommendations in real-time.</li> <li>• The system automatically codes consultations, which supports the GP practice in achieving its quality outcomes framework (QOF) points.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased trust and credibility for IP pharmacists, which facilitated greater willingness from GPs to support the IP service.</li> <li>• Increased patient safety.</li> <li>• Issues with data sharing.</li> </ul>
CMOC36	Having a different IT system for IP rather than using an existing system.	Switching between different IT systems for prescribing, for making clinical notes, and for making notes on the Patient Medication Record (PMR) system, and for service payment.	<ul style="list-style-type: none"> <li>• Increased administrative burden and may reduce consultation time.</li> <li>• Potential patient safety concerns (especially for long-payment).</li> </ul>

			<p>term condition model).</p> <ul style="list-style-type: none"> <li>Does not facilitate meaningful and efficient collaboration in the patient' best interest (their management and outcomes)</li> </ul>
CMOC37	Funding was provided to Pathfinder sites via ICBs but not ring-fenced.	Access to the funding needs to be considered against the system's other priorities.	Delay in getting funds needed to support Pathfinder sites, for e.g. project gateways, plans, risk logs, complexity assessments, honorary contracting.
CMOC38	Two-pharmacist model	Requires two pharmacists to be present at the pharmacy to enable IP pharmacists to focus on delivering IP	<ul style="list-style-type: none"> <li>If not, IP consultations would need to be "squeezed" in between the pharmacist's other daily business tasks to make it financially viable.</li> <li>Unsustainable to employ two pharmacists.</li> </ul>