

**Primary Care Pharmacy Expert Advisory Group Agenda
Tuesday 17 March 7-9pm**

To be held virtually via MS TEAMS

1: Welcome, introductions, apologies and matters arising Led by Chair (10 mins)

Previous meeting	
Description	1) Welcome and apologies 2) Actions and recommendations agreed at last meeting.
	Attendees: Jen McCutcheon, Rosie Furner, Shasta Chimhau, Stacey Middlemass (Chair) Speakers: James Davies, Vicky Chaplin Observers: Alun Kurmaully, Amrita, Chiamaka, Ethan Wilson, Pavita Gandham RPS Staff: Heidi Wright Apologies: Anne Thomson, Clair Huckerby, Hadeel Mohammed, Mohammed Rahman, Tom Kallis, Danny Bartlet Absent: Afeera Aleem, Aiysha Raoof, Alex Leng, Nazir Hussain, Raj Bajwa,

2: Genomics – Vicky Chaplin (60 mins)

Purpose	Genomics will become an integral element of mainstream care - as highlighted by the 10 Year Plan in England - and the role of pharmacy is central to enabling genomics informed medicines optimisation. ▪ The strategic approach to upskilling the pharmacy workforce in genomics was set out in 2024: NHS England » Pharmacy genomics workforce, education and training strategic framework ▪ A huge amount of work and engagement has happened over the last couple of years and key resources and highlights can be found here: Genomics in Pharmacy - Genomics Education Programme ▪ Colleagues in the NHSE Genomics Pharmacy Workforce Group and NHS Genomic Medicine Service are keen to ensure we reach all members of the pharmacy workforce in readiness for future service developments. We are keen to have active engagement and feedback on what may be required to support colleagues to prepare to support patients in genomics informed medicines optimisation. ▪ The aim of the item will be to provide an overview of the NHS Genomic Medicine Service and the delivery of genomics
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	informed medicines optimisation now and in the future, with a focus on the role of pharmacy professionals. We would welcome a discussion on roles and requirements for pharmacy professionals - particularly in terms of workforce, training and education support that is likely to be required and reflections on how best to engage and support all colleagues. A helpful tool for these discussions may be these personas we developed for different sectors: Pharmacy personas to support genomics-informed medicines optimisation - Genomics Education Programme
Outcomes	1) Setting the national genomics context and direction of travel • Genomics is positioned as a strategic NHS priority, with a shift from <i>reactive</i> testing (single indications) to more <i>integrated and eventually pre-emptive</i> use. • The NHS Genomic Medicine Service is nationally commissioned in England, organised around seven lab-centred “geographies,” and evolving toward clearer clinical functions (cancer, rare disease, and population health). 2) Pharmacogenomics as a growing (but currently limited) service • Current pharmacogenomic testing volumes are relatively small compared with overall genomics (e.g., DPYD in cancer dominates; other examples include TPMT/NUDT15, CYP2C19 for specific drugs, and mitochondrial RNR1 for aminoglycosides). • Future expansion areas discussed include NICE CYP2C19/clopidogrel implementation (not yet nationally commissioned) and broader panel testing informed by the PROGRESS study findings. 3) Evidence, pilots, and “Networks of Excellence” to bridge research into commissioning • Implementation is being shaped by pilots and evaluation work (e.g., PROGRESS in GP practices; stroke pilot for CYP2C19). • Networks of Excellence are framed as a mechanism to generate real-world implementation evidence and answer “why isn’t this everywhere yet?” (infrastructure, service model, workforce, decision support, affordability). 4) Digital infrastructure and the challenge of “making results usable” • A major theme is that genomics is “not just a test”: it needs end-to-end digital and service infrastructure. • Priorities include digitising the test directory, digitising ordering/results workflows, and developing the Unified Genomic Record feeding into broader records/applications. • Practical necessities include structured coding (SNOMED CT), clear discharge communication, and standards so results can trigger clinical decision support (CDS). 5) Clinical decision support vs alert fatigue in primary care

- Participants emphasise that primary care clinicians often won't re-check the BNF after initiating therapy; safety needs to appear *in the clinical system*.
- There's strong concern about alert fatigue—pop-ups can be ignored—so alerts need standardisation, severity frameworks, and “right-sized” prompting.
- Interim approach: only implement alerts where actionability is clear and supported (e.g., citalopram poor metaboliser example), while building the broader framework.

6) Workforce readiness: education, competencies, and “how to reach people”

- Workforce education is framed as essential because medicines touch every setting; primary care will increasingly need capability.
- Discussion covers embedding genomics into undergraduate curricula, and upskilling the existing workforce through CPPE, prescribing competency resources, and curated “single-page” resource hubs.
- A recurring challenge is engagement: clinicians (especially early-career staff) are flooded with training offers, so dissemination must be targeted, practical, and integrated into existing pathways (e.g., Primary Care Pharmacy Education Pathway / existing comms channels).

7) Broadening the target audience beyond pharmacists

- The group stresses multi-professional prescribing: nurses, paramedics, physios and other HCPC registrants with prescribing roles should be included via prescribing programmes/schools and competency frameworks.

8) Role of pharmacy technicians and wider pharmacy team models

- Strong endorsement that pharmacy technicians should be explicitly included; they are viewed as a capable workforce group to support implementation (with parallels drawn to existing services like familial hypercholesterolaemia pathways).

9) Governance, guidance, and regulatory alignment gaps

- There's recognition that licensing and MHRA communications may not provide sufficiently actionable pharmacogenomics direction.
- “CERSI guidance” is described as filling the gap with practical implementation guidance, coding standards, and decision-support-enabling detail.

10) Patient/public acceptability and direct-to-consumer testing

- Public attitudes towards pharmacogenomics are described as broadly positive, supporting rollout.
- Clinicians also need awareness of direct-to-consumer genomic results that patients may bring into consultations, requiring a consistent response and reference points.

Resources shared at the meeting:

	• https://www.rpharms.com/development/pharmacogenomics • https://www.rcgp.org.uk/representing-you/policy-areas/genomic-position-statement Vicky's email will be shared with group members Action: VC to share slides with group
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3: Medicines shortages – Chair and James Davies, CPE (30 mins)

Purpose	To understand the issues around medicines shortages from perspectives across primary care • To understand due to shortages of medications, suppliers increase cost of medications, the Drug Tariff does not cover, and community pharmacies refuse to order / dispense. This is then passed to Primary Care Team to 'provide alternative as item OOS' • Share best practice – how are individuals managing out of stock queries at their practices? • Ideas of how we can collaborate with community pharmacies around this issue e.g. Whatsapp / local comms. • Community Pharmacy England and Department of Health and Social Care share price concessions each month via CPE newsletter – do individuals use this resource?
Outcomes	• Medicine shortages are being driven by both availability and economics: Even when a product exists somewhere in the supply chain, community pharmacies may be unable to obtain it at a price that makes dispensing financially viable. • Misalignment between pharmacy purchase prices and NHS reimbursement (Drug Tariff): The Drug Tariff pricing lags behind real market prices, creating periods where pharmacies would dispense at a loss—sometimes dramatically (e.g., large gaps between tariff and acquisition cost). • Erosion of financial sustainability in community pharmacy: Pharmacies face rising workload, squeezed margins, cashflow pressure, and closures (especially among larger chains and increasingly vulnerable independents). This shapes day-to-day decisions about what can realistically be supplied. • Limitations and loss of confidence in the “price concession” system: Although price concessions are meant to correct reimbursement when prices rise, they can be slow, averaged

	across the month, and may still leave a significant proportion of pharmacies out of pocket—reducing trust in the mechanism. • Operational complexity of medicines purchasing and distribution: Variation in wholesaler access, regional depot stock differences, direct supply schemes, and “low spend” surcharges mean “in stock” does not necessarily equal “obtainable” for a given pharmacy. • Workload transfer and clinical risk in primary care: Shortages generate significant extra work for prescribers (frequent switches, monitoring, switching back later) and introduce clinical risk when patients are moved to unfamiliar alternatives. • Need for better cross-sector communication and local collaboration: Participants discuss WhatsApp groups, closer GP–pharmacy relationships, and messaging tools (e.g., AccuRx) as practical mitigations, though competition/governance barriers can limit uptake. • Tension around transparency with patients: Frustration arises when patients are told “out of stock” rather than the fuller reality (“not available at a viable price” or “not obtainable through our wholesalers”), but pharmacies may be reluctant to frame it that way due to contractual obligations and reputational concerns. • System-level advocacy and evidence gathering: Participants suggest escalating the issue politically (MP templates, public pressure) and—importantly—quantifying time/resource impact across primary care to strengthen the case for reform and funding. • Consensus that there is no quick fix: Proposed remedies range from increased funding and reforming pricing/clawback mechanisms to improved data/price-setting processes; structural change is acknowledged to be slow. Actions: • JD to share slides • HW to explore a survey for Primary care around medicines shortages
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4: Summarising Key Actions led by Chair (5 Mins)

Purpose	To summarise key action points and identify agenda items for next meeting.
	Suggested agenda items for the May meeting were: • New primary care contracts

ROYAL PHARMACEUTICAL SOCIETY

	• Neighbourhood Health Centres • Royal College Update • Education and Training update from RPS • Workforce – knowing who is where
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Dates of next meetings:

- 26 May 2026 7-9pm
- 8 September 2026 7-9pm
- 5 December 2026 7-9pm