RCGP response to the Department of Health and Social Care consultation: 'Enabling pharmacist flexibilities when dispensing medicines'

November 2025

Consultation Questions:

The DHSC propose to enable pharmacist flexibilities, allowing pharmacists to use their professional judgement to supply an alternative strength or formulation (which may mean a different quantity) of the same medicine originally prescribed, without getting another prescription from the prescriber, but only under restricted circumstances.

1. To what extent do you agree or disagree with this proposal?
   - Strongly agree
   - Agree
   - Neither agree nor disagree
   - Disagree
   - Strongly disagree
   - Don't know

2. To what extent do you agree or disagree that increasing pharmacist flexibilities would offer better patient-centred care?
   - Strongly agree
   - Agree
   - Neither agree nor disagree
   - Disagree
   - Strongly disagree
   - Don't know

The DHSC propose to increase pharmacist flexibilities, but only under restricted circumstances where the pharmacist considers that:

- there is an 'urgent need'
- it would be impracticable to obtain the product to meet the patient's needs without undue delay
- any alternative will enable the patient to have the same medicine at the same dose, dosage regimen and treatment cycle as prescribed

This flexibility would not apply if there was a known serious shortage of a medicine prescribed or the alternative to be supplied, subject to an easement relating to the messaging systems which are used where there are shortages which would allow those messaging systems to recommend continued use of the flexibilities during a shortage. This is to mitigate risks to patient safety, conflict of interest and the medicine supply chain.

3. To what extent do you agree or disagree with our proposal that increased pharmacist flexibilities should have these restrictions in place?
   - Strongly agree
   - Agree
   - Neither agree nor disagree
   - Disagree
   - Strongly disagree
   - Don't know

In the consultation document, the DHSC have outlined some of the considerations around patient safety, medicine supply chain and conflict of interest as part of these proposals.

4. If there are any other factors you think should be considered, please include them here - (Optional, **maximum 250 words**):

The RCGP note DHSC's consideration of supply chain impacts, and seeks strong measures to monitor medicine supply chains closely during any reform, to assess for unwanted outcomes and facilitate early intervention. 60% of 2,000 surveyed community pharmacy team members report contacting GPs daily about supply chain issues (RPS, 2025).
Medicines optimisation functions and teams should be well resourced and supported across system levels and settings, particularly during transition/reform periods while changes embed and stabilise. The College has previously expressed concern over ICB cuts and NHSE merging with DHSC, warning that essential medicines-optimisation functions could be lost or weakened, remaining concerned about where this work will sit, how it will be resourced, and whether GPs will be expected to absorb these responsibilities as unfunded additional workload. We urge DHSC to consider interface challenges.

The RCGP supports a clear, robust record-keeping process for any change to a prescribed medicine, similar to emergency supply arrangements. This could be a digitally integrated, standardised national form to ensure consistent documentation, enable systematic data collection and analysis, and support timely communication with the prescriber.
Dispensers may not know the patient's condition or history, so guidelines and governance must reflect this, protect patient safety and ensure GP advice is not overridden. To strengthen safety, we suggest a simple pharmacist–patient (or patient representative) checklist confirming: reason for change; whether it's a one-off; the patient's understanding and ability to manage the adjustment; and that it can be incorporated safely into existing compliance routines – especially relevant to vulnerable groups.

The DHSC propose that pharmacist flexibilities would not apply for controlled drugs in schedules 2 to 4.

5. To what extent do you agree or disagree with this proposal?
   - Strongly agree
   - Agree
   - Neither agree nor disagree
   - Disagree
   - Strongly disagree
   - Don't know

6. What impact, if any, would introducing pharmacist flexibilities have on patient health? We would value advice on both the likelihood and size of any health impacts - (Optional, **maximum 250 words**).

Introducing pharmacist flexibilities is expected to improve patient health by reducing delays in treatment, particularly for people with complex conditions or multiple long-term medications. The RCGP supports allowing pharmacists to substitute medication, including generic alternatives, when safe, clinically appropriate, consented to, and clearly communicated to GPs and wider care teams. Any change mustn't increase bureaucracy for GPs or add administrative steps that undermine clinical capacity. Current rules prevent supply of equivalent alternatives during shortages, creating treatment gaps, poor patient experience, unnecessary travel, and additional administrative work for GPs, pharmacies and their teams. Proposals must avoid added complexity, workload, or barriers to access.

Enabling substitution could reduce GP workload by cutting avoidable repeat prescriptions and urgent queries, freeing capacity for proactive, personalised care, prevention and long-term condition management. It may also help address health inequalities, as patients with limited access to travel or with multiple conditions are disproportionately affected by supply delays.

For most of the population, the overall health impact is likely to be limited but positive if this is delivered well with appropriate safeguards to mitigate risk. We'd expect greatest gains from earlier access and smoother care pathways for individuals with complex multimorbidity, elderly, patients managing multiple repeat prescriptions, and in rural or isolated areas.

Alongside clear guidance, targeted training and reliable systems, the safe implementation of any changes will require robust communication between pharmacies and GP practice medicines management teams, including named contacts and regular updates, to ensure consistency, mitigate risk and maximise patient benefit.

7. To what extent do you agree or disagree with our assessment that the impact of the proposal around pharmacist flexibilities on NHS medicine costs will either be cost-neutral or marginal?
   - Strongly agree
   - Agree
   - Neither agree nor disagree
   - Disagree
   - Strongly disagree

- Don't know

8. If you have any case studies, descriptions, analysis and quantification that could be helpful for discussion and/or inclusion in any overall assessment, please include them here - (Optional, **maximum 500 words**).

Automation and coding should be embedded safely and efficiently within integrated digital systems wherever feasible. When a pharmacist cannot supply a prescription as written, digital tools should support accurate and seamless recording of the replacement item and allow the addition of notes on any communication with the patient, carer, or prescriber. These digital records should be shared across service settings.

In pharmacies where robotics and/or automated dispensing tools are used, (for example using barcodes of items and/or accounting for each stock batch and expiry), there may be a way of utilising this software.
Example: Community pharmacist receives an electronic prescription for one-month supply of atorvastatin 20mg tabs (1tod m:30). The dispensing system detects low stock and cannot fill the script as written. A safety-programmed system could instead suggest clinically appropriate alternatives based on NICE guidelines and that pharmacy's current stock, for a pharmacist to review and clinically check. I.e., could identify atorvastatin 10mg in stock, and suggest supplying 60 tabs with a dosage instruction of 2t od. The system could also print an additional "supply-change" sundry label to prompt the pharmacist to counsel the patient at collection, explain the substitution, and confirm they are comfortable with it. Finally, the system would record all actions in the patient's file, which could then be shared with the prescriber manually or accessed directly in an integrated system.

Details of prescribers and pharmacists involved in the dispensing and supply aspects, should be recorded for auditing and safety measures. There should be a mechanism to account for multiple professionals, i,e. if a clinical decision is made to substitute at the point of entry, but another pharmacist checks the final prescription, this should be recorded and steps must be taken to mitigate any gaps in clinical oversight that could lead to poorer outcomes, such as the second prescription handler not noticing the change and not consulting the patient when the prescription is delivered/picked up.
This emphasises the importance of automated, inbuilt systems to flag if a change has been made, and for this to be identified at multiple check points of the medicine supply process. Pharmacies could use dispensing systems/PMR software for barcode-linked prompts at the point of handing a prescription out to a patient, to alert when a medicine differs from the item originally prescribed. This is another opportunity for pharmacists to review a dose change or formulation switch and consult patients, strengthening the overall safety net. While some UK pharmacies may use such functions, New Zealand offers international examples.

Utilisation and improvements of existing software could streamline medicines access process, minimise human error, and allow for more efficient use of the skills across services by saving time

spent on administrative tasks. It is ultimately important that the prescriber, dispenser, and end user (primarily the patient but may also include carers within this consideration) are able to communicate effectively, to be fully informed, consenting of treatment, and aware of where to access information.

Additionally, safe substitution and generic replacement should be considered in any reform.

Overall, the RCGP support greater pharmacist flexibility to substitute medication where this is safe, clinically checked, consented to, and clearly communicated to improve timely access to treatment. Any changes must be designed to avoid adding bureaucracy or shifting workload in ways that create new barriers to timely access or increase administrative pressure on GPs and pharmacies.

9. Where a pharmacist has utilised flexibility to supply an alternative medicine, to what extent do you agree or disagree that the pharmacy should notify the prescriber?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

10. Do you expect pharmacists would need specific training if pharmacist flexibilities were enabled? If yes please provide details (Optional, maximum 250 words)

- Yes
- No
- Don't know

We support in principle allowing pharmacists greater flexibility to substitute medication, provided it is safe to do so, appropriate clinical checks are undertaken, the patient agrees, and any changes are communicated clearly with relevant health care professionals. Proposals must be designed and implemented in a way that does not create new bureaucracy or workload shifts that reduce clinical capacity.

Targeted training should be required to ensure consistent, safe and clinically appropriate implementation across community pharmacy settings. Substitution decisions involve assessing therapeutic equivalence, identifying clinical risks for specific patient groups and documenting changes clearly for the wider multidisciplinary team. Evidence from the Community Pharmacy Consultation Service indicates variation in clinical confidence and workflow practices across the sector. Additional research identified inconsistent approaches to clinical assessment and communication, particularly for people with multimorbidity and polypharmacy (Tsang, 2024).

Training could cover three key areas. First, strengthening clinical skills and decision making, including around bioequivalence and pharmacokinetics, dose conversions, modified release preparations and medicines with narrow therapeutic windows. Second, structured communication pathways, including timely notification to the prescribing clinician and advice for patients. Third, governance and patient

safety processes, including use of incident reporting systems and accurate record keeping on PMR systems.
If designed well, training would facilitate a well-defined responsibility and support a shared understanding between pharmacists and GPs. This could help mitigate risks of fragmentation noted in CQC reviews of primary care integration.

The DHSC propose that if pharmacist flexibilities were enabled, they would not be supervised by pharmacy technicians.

11. To what extent do you agree or disagree with this?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

12. Do you agree or disagree with DHSC and the Department of Health in Northern Ireland, who do not consider that these policy proposals will create inequalities or adversely impact individuals with protected characteristics?

The protected characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

The Department of Health in Northern Ireland does not consider that these policy proposals will impact people differently with regard to where they live geographically in Northern Ireland.

13. Do you agree or disagree with this assessment?

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

Thank you.

ENDS.