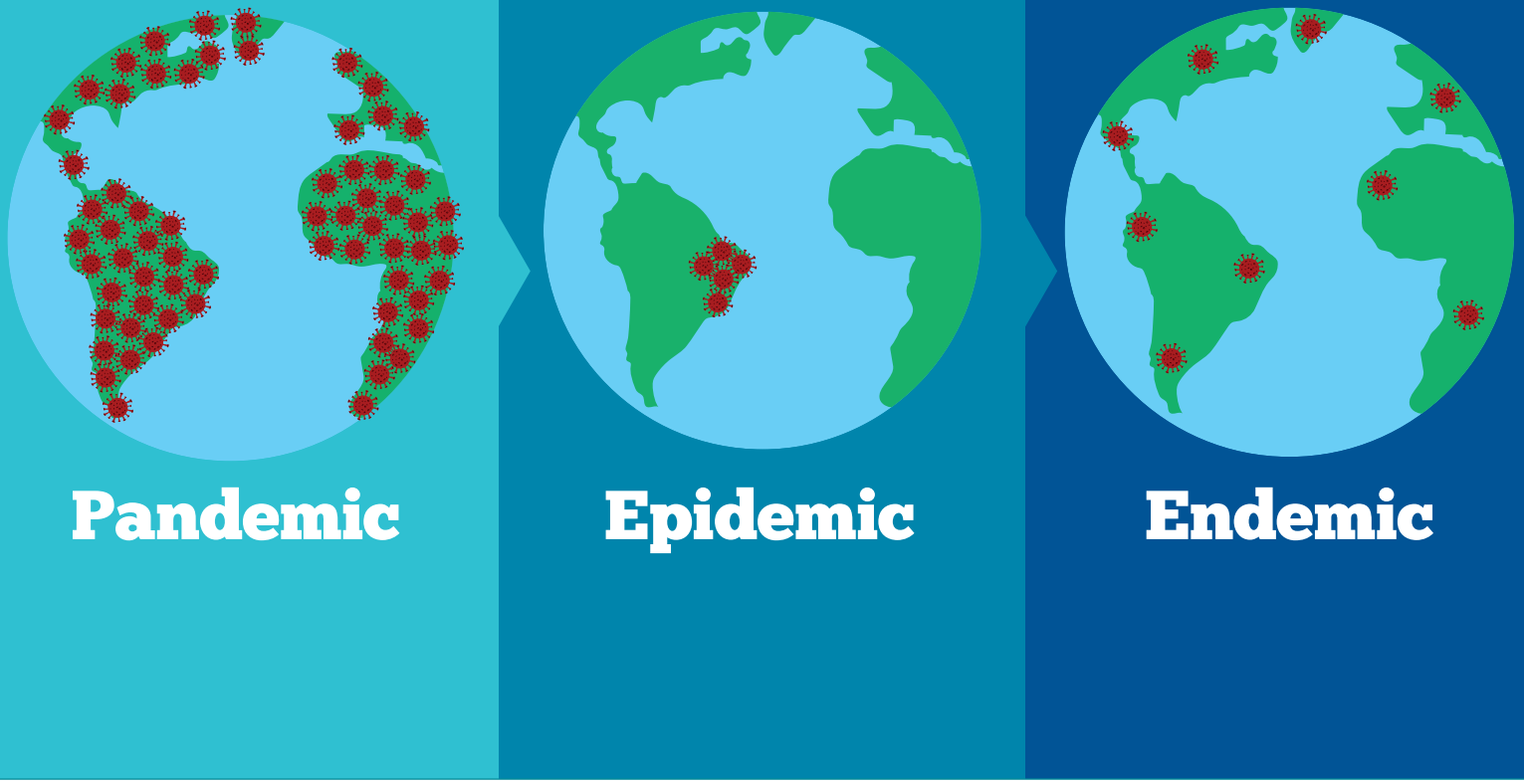

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How lessons learned during the Covid-19 pandemic can help to support better integration in NHS Primary Care

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Foreword

Philip Hunt, Baron Hunt of Kings Heath, OBE, PC

The Covid pandemic became the largest modern-day pandemic in living memory, causing not only a healthcare crisis, but also widespread disruption of entire economies and systems across the world.

In the UK, the initial lockdowns resulted in the healthcare service being turned on its head. Initially without a vaccine or a cure, the hospital service was primarily focussed upon treating hundreds of thousands of patients, many who became very seriously ill and many ultimately died.

With many hospitals filled to breaking point, they were less able to deal with the waiting lists of patients requiring routine and, in some cases, urgent non Covid related health conditions. In primary care, a very large proportion of GP surgeries stopped taking face to face appointments and relied instead on virtual appointments; and this is a practice that continues today. To a large extent, the community pharmacy became the only healthcare facility which could still be accessed by patients on a face-to-face basis and despite the lockdowns, this resulted at times in over 30% increase in the numbers of patients attending their local community pharmacy.

Later, during the second phase of the pandemic during which the world beating vaccination program was rolled out, pharmacists played their part again, unexpectedly delivering most of all vaccinations administered in primary care through community pharmacy led hubs. As we emerge from the pandemic, many things have changed – some forever. One of these is the understanding that pharmacy can provide a much more comprehensive contribution to healthcare than was ever contemplated before.

This revelation is timely as across society and particularly across healthcare, now more than ever before the need to look imaginatively at how we spend limited financial resources has become apparent. It is time to challenge accepted norms and to reflect upon and learn lessons in the way that healthcare was challenged and how it responded. It is time to apply some of these learnings in a post Covid world. The post Covid period provides an opportunity to reconfigure parts of the system and to create new collaborative operational frameworks that can not only drive down the unmet needs, but also deliver benefits to the NHS, the taxpayer and most importantly of all to the patients.

This series of post Covid proposals seek to exploit the best lessons that emerged during the crisis. Through a collaborative multidisciplinary approach with a much greater involvement of pharmacists it creates a community of practice which is managed by a local primary care organisation. These proposals aim to break down the historical silo approach that has always been taken by policymakers to healthcare delivery especially (but not exclusively) in primary care and they aim to make healthcare far more accessible to patients in their local communities.

The NHS and its personnel have always worked hard but with waiting lists at record levels and much greater challenges brought about by changing demographics on their way; the time has now come to focus upon working smart.

I hope that the NHS can engage with these innovative proposals as they represent a powerful contribution to the post Covid healthcare debate.

About the PDA

As the largest representative body and only independent trade union exclusively for pharmacists, with 35,000 members, the Pharmacists' Defence Association (PDA) is the voice of pharmacists working on the NHS frontline and across all healthcare settings, including GP practice, Community, Hospitals and Prisons.

Executive summary

- The Covid-19 pandemic presents an imperative to rapidly set a more ambitious programme for how the healthcare system can be re-engineered to ensure that the old inefficient silo approach is replaced with a more collaborative and integrated multidisciplinary system both within primary and secondary care. Improved collaboration reduces the likelihood of A&E attendances and unnecessary hospital admissions and creates benefits for the healthcare team, the NHS, the taxpayer and most importantly improves the patient's journey.
- Pharmacy becoming '**the first port of call**' to the primary care system would result in a move away from an expensive, increasingly challenged medically led model of the NHS. These proposals utilise the highly accessible location of community pharmacies, the expertise in medicines possessed by pharmacists and the huge possibility for opportunistic interventions involving both population and public health and the delivery of pharmaceutical care services.
- Through a collaborative framework which is connected to other parts of the system it would herald a time of greater, more proactive collaboration between the individual components of the system creating much greater capacity by ensuring that its various components are not just working hard, but also working smart.
- Many of these proposals could be provided through arrangements independent of the current pharmacy contract for medicines supply giving owners the opportunity to create more of a health centre offering and move away from the appearance of being a shop.
- With a realignment of primary care contracting, GPs could refer caseloads of patients that they have already diagnosed with long term conditions to clinic pharmacists who would deliver detailed pharmaceutical care on an individual named and registered patient basis. This could provide GPs with more capacity to concentrate their efforts on the acute needs of patients as well as being more able to proactively tackle latent problems through the operation of virtual wards, the effect being to prevent unnecessary A&E attendances and avoidable hospital admissions.
- These proposals are predicated on a model where at least two pharmacists are working in the pharmacy, one in an opportunistic patient facing role, and one leading clinic activity in the consultation room with planned caseloads both supported by full access to the patient record.
- The PDA proposals describe new services and patient pathways. Whilst these deliver broader outcomes for the NHS and an improved patient journey, they also result in a much more clinically engaged and professionally rewarded pharmacist workforce; going some considerable way to alleviate some of the current causes of pharmacy workforce pressure.
- By focusing on making early interventions and quality referrals, many of the inefficiencies and costs of the silo working in the system can be significantly minimised.

Strategic Recommendations based on the experience of Covid-19

- Optimise technology as a means of communication between all parts of the health and social care system.
- Take advantage of the fact that GPs can now be available on a virtual basis.
- Focus on the population and public health opportunities based on the high numbers of patients coming to the community pharmacy and ensure they receive care based on the principle of making every contact count.
- Create new and more efficient referral pathways where necessary.
- Incentivise healthcare providers and NHS organisations through harmonised contracts and outcomes to make collaboration and integration a reality.
- Identify points in patient pathways where collaboration can work.
- Empower patients, their representatives, and all parts of the healthcare system to help design a more joined up system which improves the NHS experience.

Introduction

It is a well-known fact that pharmacists are an undervalued asset of the NHS, they want to make full use of their clinical knowledge and skills, however the opportunities for them to reach their professional potential have yet to be fully realised. Meanwhile, other parts of the system, especially General Practice are at breaking point.

The necessary recovery and restoration of NHS services in the aftermath of the Covid-19 pandemic presents a significant opportunity for the redesign of healthcare in the UK. The recognition and the application of the skills and scope of the contributions from pharmacists could introduce big improvements to the system.

Reimagining the working model for pharmacists as part of the wider system through collaboration could be transformative to the health and pharmaceutical care of patients. However, the current model, funding and workforce structure does not enable this.

In a recent keynote speech[1] to the NHS Confederation, the erstwhile Secretary of State for Health and Social Care, Sajid Javid MP said that the current model of primary care is not working, and that a plan for change is needed. He also recognised that pharmacy was the place to begin that change and that he would be setting out plans soon.

Community pharmacies, based in the heart of local communities are now, more than ever seen as a healthcare access point, with the majority providing a range of services delivered in the privacy of consultation rooms. Pharmacy is also highly accessible and according to statistics[2] from the Pharmaceutical Services Negotiating Committee (PSNC);

- *Around 1.6 million people visit community pharmacy every day in England alone.*
- *89% of the population in England has access to a community pharmacy within a 20-minute walk.*
- *Over 99% of those in areas of highest deprivation are within a 20-minute walk of a community pharmacy; and*
- *As the accessibility of community pharmacies is greatest in areas of higher deprivation, they may have an important role to play in reducing inequalities.*

Building on their experience of the annual flu vaccination programme, pharmacy teams have been instrumental in the roll-out of Covid-19 vaccinations, demonstrating the ability for the sector to be mobilised at scale to deliver significant health programmes across a national footprint and reach demographics which other parts of the NHS may find challenging. The Covid-19 vaccination programme also demonstrated how the establishment of standalone hubs enabled community pharmacy in England and Wales to undertake the heavy lifting on the overall national vaccination programme.

However, while pharmacists are working hard, they are not always empowered to work to their maximum potential. With 35,000 members, the PDA is the largest pharmacists' membership body in the UK, representing

[1] DHSC – Secretary of State NHS Confed speech

[2] PSNC - About community pharmacy

members in all areas of practice. Through our engagement with them, our members have proposed changes to the way services and patient pathways are developed, to deliver sustainability, a more holistic approach to deliver better patient outcomes, and ways to develop a highly engaged and professionally rewarded pharmacist workforce.

The opportunity and scope presented by the pharmacist workforce and a local network of physical healthcare facilities has been a feature of healthcare policy across all four UK nations for some years with varying degrees of implementation. The Covid-19 pandemic presents both an opportunity and an imperative to rapidly set a more ambitious programme for the sector to be enabled, through policy and funding to meet its potential.

The PDA's long-term strategy for the pharmacy sector **Wider Than Medicines**[3] describes how the patient journey is at its best when the various members of the healthcare team can focus upon their unique professional skills. In the case of GPs, this is diagnosing patients; for hospital staff this is providing specialist treatment, and for pharmacists, this is the safe and effective use of medicines and specifically in the provision of pharmaceutical care. This can only occur if it is done within a managed and coordinated framework.

Fundamentally, a new approach is needed to the way that pharmacists work in community to achieve better integration and patient outcomes around pharmaceutical care. This will require at least two pharmacists working in the community pharmacy for most if not for all of the time. One delivering patient facing care around medicines use and using the prescription as an opportunity to make a clinical intervention and the other running pharmaceutical care clinics and managing caseloads of patients on an appointment led basis as part of a multi-disciplinary primary care team. Widening access to the full patient electronic record is also a key enabler to pharmacists working as part of the wider primary care system.

By focusing on interventions throughout the patient care journey, some of the existing silo working can be eliminated from the system. Through the creation of a **community of practice** we can ensure that pharmacists, doctors and others across all sectors can apply their unique skills collaboratively, so that they can achieve joint objectives in a much more efficient and joined up way.

The PDA's **Wider Than Medicines** policy explores what contribution pharmacists as experts in medicines can best make in this new joined up **community of practice**.

Through appropriate use of skills of the pharmacist (this is increasingly the case with the widespread emergence of pharmacist prescribers) and the whole pharmacy team, there are a wealth of opportunities to improve population health and support optimal medicines use. With better integration, this further reduces pressure on other parts of the health and care system through increasing collaboration between pharmacists, GPs and other health and care professionals both in primary and secondary care.

The long-term health of the NHS

The Covid-19 Pandemic has undeniably, and permanently changed the health and social care landscape across the UK, and indeed globally. The economic situation means that the NHS is at a critical stage in its own health and sustainability.

Different approaches to the response to the pandemic from national leaders will no doubt be analysed and well documented in the fullness of time, however as we are moving from pandemic to endemic status, where Covid-19 is likely to be as much of a regular feature as is the influenza virus, there is a necessity to reinstate and resume substantial levels of services. There is a need to address the known backlogs in healthcare which have increased because of the pandemic, and to address the potentially unknown, unmet need which may lead to further increased demands on the health and care service in the future. Beyond all of this, a new approach to the delivery of Social Care and its more general integration with healthcare has yet to be found.

Already still adapting and adjusting to the additional demands and difficulties caused by the pandemic, the service is embarking on significant structural evolution around the integration of services while workforce and workload pressures across all parts of the system are reaching crisis point.

[3] PDA – Wider Than Medicines

Concerns include:

- Research from the Kings Fund[4] suggests that the NHS backlog stands at around 5.61 million people, which equates to one in ten people in England, and that those waiting for treatment are from the most deprived communities.
- The number of people on the waiting list is expected to increase further with the former Secretary of State for Health warning that it is 'going to get a lot worse before it gets better' and could grow to 13 million[5].
- Covid-19 is a factor in disparities around health outcomes and in some cases leads to an increase in health inequalities[6].
- An estimated 1.8 million people living in private households in the UK (2.8% of the population) were experiencing self-reported long COVID (symptoms persisting for more than four weeks after the first suspected coronavirus (COVID-19) infection that were not explained by something else) as of 3 April 2022[7].
- Reports of some patients experiencing reduced access to general practice. HealthWatch and the Care Quality Commission have recorded a rising number of concerns and complaints, typically about appointment availability, waiting times, and in particular, the ability to see a GP, and specifically face-to-face[8].
- According to Macmillan Cancer Support, up to 50,000 people in the UK have cancer but have not been diagnosed because of disruption caused by the pandemic, which, at best, could take a further 18 months to tackle in England alone[9]. The charity predicts that the number of cancers left undiagnosed could double in a year if the delays in cancer referrals and screening are not fixed.
- The growing mental health crisis, statistics from the Office for National Statistics, revealed that depression rates have doubled since the COVID-19 pandemic began.

Challenges for Primary Care

As the inclusion of different types of healthcare professionals including pharmacists in general practice throughout the UK increases, this provides the opportunity for expertise to be deployed to support patients with their specific needs and conditions. However, the organisation of these skills into an effective service has not yet been achieved.

A recent report from the King's Fund[10], Integrating additional roles into primary care networks, found that there is some confusion around strategy of widening participation of multi-disciplinary working through the introduction of Additional Roles Reimbursement Scheme (ARRS) funded roles, which is *"**linked to a lack of agreement about whether the roles are primarily intended to deliver the requirements of the Primary Care Network (PCN) contract or to undertake what might be considered the 'core' work of general practice**"*.

The report also found that the *"**potential contribution of additional roles to general practice is not universally understood**"* and that there is *"**ambiguity***

[4] King's Fund Report – Tackling the elective backlog
[5] BBC News Report
[6] gov.uk - Review of disparities in risks and outcomes
[7] ONS - Prevalence of ongoing symptoms following Covid-19
[8] NHS England and Improvement - Plan for improving access for patients and supporting general practice
[9] Sky News Report on cancer diagnosis
[10] King's Fund – Integrating additional roles into Primary Care Networks

among some GPs about what multidisciplinary working would mean for them and their working practices, both clinically and in the way in which their practices are run".

Greater alignment of contractual frameworks and improved formal and informal working arrangements between general practice and community pharmacy could support the integration and collaboration agenda, deliver enhanced outcomes for patient care and the requirements for organisations, while confirming pharmacists as part of the multi-disciplinary team regardless of the setting in which they work.

A different approach to the mobilisation of the pharmacist workforce could free up significant capacity.

The Covid-19 crisis has shown that the time to re-engineer the system to not only improve the patient journey, but also to use limited NHS resources to much better effect has surely arrived.

Primary care is much wider than the GP practice, and not all care has to be funnelled through this route.

Re-imagining primary care

Many of the operational and hypothetical concepts that previously may have been considered to have been radical have, during the Covid crisis become a reality, and a rapid albeit forced transformation has produced some surprising outcomes.

In particular, the fact that the GPs held their appointments primarily via virtual means while community pharmacies saw an estimated 30% increase in visits during the period and became the main physical access point.

Pharmacy as '**the first port of call**' to the primary care system is a particularly powerful example of how it might be possible to make changes going forward. This could result in a move away from an expensive, increasingly challenged medically led model of the NHS where patients struggle to get an appointment and even when they do, they may wait a long time.

The current system, where more than 20 million appointments for conditions that do not require the intervention of a GP are wasted, could benefit from a move towards a more accessible more convenient and less costly community pharmacy led model. This could enable the more complex patient presentations such as those requiring complex diagnosis, to be referred to other parts of the system to include the GP much more effectively.

This would require a re-alignment of primary care contracting, where GPs could refer caseloads of patients that they have already diagnosed with long term conditions to clinic pharmacists who would deliver detailed pharmaceutical care on an individual named and registered patient basis. In turn, this could provide GPs with more capacity to concentrate their efforts on the acute needs of patients to prevent unnecessary A&E attendances and avoidable hospital admissions.

A pharmaceutical care approach - focussing more on medicines would deliver significant benefits for the NHS.

The NHS spends in the region of £16 billion a year on medicines, of which around £9 billion arises from GP prescribing. Prescribing medicines is the most common medical intervention and it represents after staff costs, the second highest item in the NHS budget – and yet the system is not taking medicines seriously enough.

For example, research[11] has found that;

- *£300million worth of NHS medicines is wasted each year*
- *up to 50% of medicines are not taken as intended by the prescriber*
- *between 5 to 8% of all unplanned hospital admissions are due to medication issues (this figure rises to 17% in the over 65s)*
- *estimated opportunity cost of the health gains foregone because of incorrect or inadequate medicines taking in just five therapeutic contexts that is more than £500 million per annum*
- *multi-morbidity and polypharmacy increase clinical workload, so doctors, nurses and pharmacists need to work coherently as a team with a balanced clinical skill-mix.*

[11] NHS England - Medicines optimisation

The recent report "**Good for you, good for us, good for everybody**" from NHS England and Improvement[12] also highlighted;

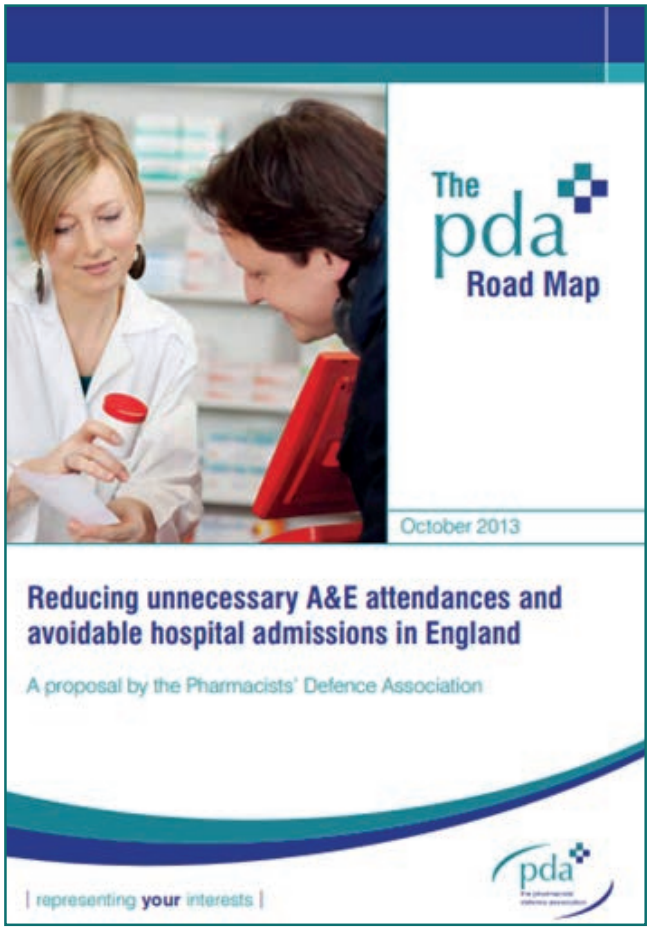
- *overprescribing can lead to more hospital visits and preventable admissions, even premature deaths.*
- *overprescribing may disproportionately affect Black, Asian and Minority Ethnic communities and those who are more vulnerable, such as the elderly and those with disabilities.*
- *evidence is limited, but the review estimates that it is possible that at least 10% of the total number of prescription items in primary care need not have been issued.*

A greater focus on pharmaceutical care with pharmacists working in a variety of settings at its heart, could play a significant part in improving patient outcomes, have a positive impact on the over-prescribing agenda, and secure better value from medicines for the public purse.

Pharmaceutical Care is defined as: "*A patient-centred practice in which the practitioner assumes responsibility for a patient's medicines related needs and is held accountable for this commitment.*"

The PDA's **Road Map for England**[13] suggested this could be done by;

- **Preventing hospital admissions through smarter care of patients** using a virtual ward approach across the whole of England
- **Reducing adverse drug reactions through Pharmaceutical Care** with pharmacists providing educational information, medicines use optimisation services and support to patients, enabling them to take greater control of their medicine regimes.
- **Reducing medicines wastage through Pharmaceutical Care** with an emphasis on health outcomes rather than waste reduction alone. With outcome measures across both the GP and community pharmacy contracts, the initial focus could be on specific therapeutic areas enabling significant improvements around asthma, diabetes, raised blood pressure, vascular disease and care of people with schizophrenia.

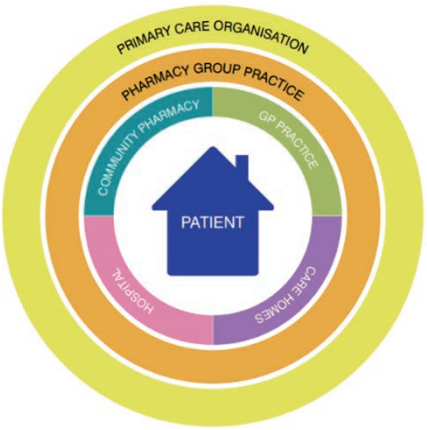


[12] NHS England and Improvement - Good for you, good for us, good for everybody

[13] PDA – Roadmap

Co-ordination of care across a range of primary care providers

Like the conductor of an orchestra, the local primary care organisation could coordinate the local management of care between a variety of organisations, care providers and settings.



Local Primary Care Organisations reducing inequality and variation

- Using risk stratified data to identify local health needs and align services.
- Understanding local population demographics and health economy related challenges to prioritise services.
- Focussing on pharmaceutical care and medicines safety.

Prioritising services to meet local needs

Looking at the national health landscape and developing and managing tailored, place-based interventions for consistent delivery at scale through local co-commissioning of services.

How could community pharmacy deliver a pharmaceutical care approach in England?

The reimagining of the model for pharmacists could be transformative to the health and pharmaceutical care of patients, however currently the model, funding and workforce structure does not facilitate this.

The PDA propose a change to the way services and patient pathways are developed, to deliver sustainability, better patient outcomes and a highly engaged and professionally rewarded pharmacist workforce, as described in **Wider Than Medicines** and **Road Map** policy papers.

The existing pharmacy contracting arrangements could be supplemented by additional tiers of services that are much more clinical and integrated within the primary care system to be delivered by individual pharmacist practitioners possibly through group practices of pharmacists – these would be a similar concept to that of a barristers' chambers. Contracts should be complementary across primary care to incentivise collaboration and integration; partnership working and sharing of health outcome measures.

As well as providing improved care for patients, the integrated nature of these new services would release significant GP capacity however, such proposals could only succeed in the long term if it was delivered within a locally managed and coordinated framework.

By focusing on interventions throughout the patient care journey, many of the inefficiencies and costs of the silo working in the system could be eliminated.

Examples of service developments that would result in greater collaboration and integration

The following proposals are starting points for discussion to further explore how pharmacists, and their teams could make full use of their skills and expertise. They consider too, how best to use the positioning and accessibility of the community pharmacy. Some may not be new or be previously unexplored concepts, however the referral pathways and proposals about how these services could be integrated into the health and social care landscape could be developed to provide a better patient journey and a more efficient approach.

1. Pharmacy as the first port of call

This proposal advocates a move towards a much more accessible and more convenient community pharmacy led model, which is a lot less costly than the current medically led model. With the emergence of virtual medicine becoming one successful operational bonus from Covid, the community pharmacist would handle initial walk-in patient presentations, with, if necessary, the ability to call in a doctor or other relevant healthcare professional virtually in cases that needed additional support (potentially utilising local primary care hub GPs available to support such a virtual support requirement).

Further adoption of diagnostic testing could see an increase in the scope of the Community Pharmacist Consultation Service, to cement pharmacy as the first port of call. Such a service could reduce antibiotic use in patients with acute infections by utilising pharmacists' clinical skills in assessing symptoms and providing suitable treatment and advice, for example in throat infections and Hepatitis C. Point of Care (POC) testing for C-Reactive protein (CRP) is already utilised in several European countries to reduce antimicrobial prescribing[14].

The development of more independent prescribers in community pharmacy will also enable faster initiation of treatment for some conditions meaning that further capacity could be released in primary care.

Triage or treatment?

Within such an operational framework, the pharmacist would then either directly instigate treatment (for a minor condition) issuing a prescription and sending the patient home (avoiding an unnecessary visit to the GP surgery or A&E department) or refer the patient to another part of the system, using on line technology to book an appointment where appropriate (be that the GP surgery, a secondary care referral or elsewhere).

Under such changes, GP surgeries would also refer those cases that they think could be handled in a community pharmacy to the pharmacy, the public would be actively encouraged to use the community pharmacy for opportunistic walk-in appointments as a 'first port of call' and the NHS on-line booking service would direct patients to community pharmacies where appropriate.

Advantages

- Better manage the pressure on GP surgeries as they refer those cases that they feel could be handled in the community pharmacy (just as they did during the Covid crisis) without the need for an appointment.

- Ensure best use of GP surgeries through appropriate use of their expertise.
- Reduce the pressure on GP surgeries as they handle only those cases that they decide require their input, or they receive referrals and booked appointments from the pharmacy.
- Provide more timely resolution of problems for patients on a walk-in basis and address the issue of inadequate GP appointment availability. Patients enjoy a resolution to their problem without an appointment and no longer need to rely on the hope of an available appointment in the surgery.
- More than one pharmacist working in a community pharmacy would produce a far greater capacity to build upon, providing a much greater opportunity to make an ever-greater number of services available from the community pharmacy setting.

Changing working practices

- New GP triaging system to actively encourage many more patients to be treated elsewhere.
- GPs would concentrate on the much more acute presentations and on proactive work such as virtual ward activity.
- New patients coming to the community pharmacy first to be triaged – either treated or referred on elsewhere.
- Hubs involving doctors and other healthcare professionals established to support pharmacy patient consultations virtually where necessary.
- Referral pathways created to enable bookings to be made on-line.
- ICS/PCN pharmacist teams to support the clinical governance, quality and training arrangements to reduce inequality and variation.
- Community pharmacy employs more than one pharmacist and begins to look more like a clinical setting and less like a shop.
- Pharmacist responsible for the clinical checks on prescriptions, but no longer for their assembly.

Changing workforce roles

- Community pharmacists providing the primary care triaging role.
- Greater role for pharmacy technicians in the technical aspects of dispensing to support an optimal skill mix and pharmacists providing more patient facing activity.
- Specialisation of both pharmacists and pharmacy technicians is kickstarted.
- GPs becoming more of a pre-screened referral pathway (as they did during the Covid crisis) enabling them to concentrate on the much more acute presentations that only they can deal with and on proactive work such as virtual ward activity.
- Roles for doctors and others in central hubs to support decision making virtually.

Case study

John is a busy sales rep with a full-time job. He has been having symptoms but feels that he cannot afford to take time off to arrange and attend a GP appointment at his surgery.

He has just finished a sales visit in his local area and notices the poster in the adjacent pharmacy window stating that they provide walk-in appointments for urgent care. As John has been having some renewed symptoms he pops into the pharmacy and is seen in the consultation room within 15 minutes.

When he explains his symptoms to the pharmacist, he is told that there could be a cause for concern and asks John if he would allow the pharmacist to seek virtual support from the doctor at the local primary care service hub.

They contact the hub via an online consultation and John and the pharmacist discuss his symptoms with the doctor who confirms that the pharmacist was right to be concerned. Following this consultation, the pharmacist refers John to the local gastroenterology clinic where he receives treatment for a gastric ulcer.

[14] CRP point of care testing

2. Joined up care through a Community of Practice delivered by a locally managed system.

Currently, pharmacists are working in a variety of settings across communities, in the traditional community pharmacy, in GP surgeries, in hospitals, in care and residential homes, in primary care organisations and other places. They are not only dispensing medicines, but also providing services, care and advice. They are increasingly developing new roles designed to alleviate the pressure on GPs and other parts of the system.

The patient journey is at its best when the various members of the healthcare team can focus upon their unique professional skills. In the case of GPs, this is diagnosing patients; for hospital staff this is providing specialist treatment, and for pharmacists, this is the safe and effective use of medicines and specifically in the provision of pharmaceutical care.

The physical journey that patients undertake to access the healthcare service is another important consideration and here, we believe that the community pharmacy has a pivotal contribution to make.

By focusing on interventions throughout the patient care journey, many of the inefficiencies and costs of the silo working in the system could be eliminated.

The creation of a community of practice can provide wider and much more comprehensive benefits to patients than would be provided by any sole individual healthcare provider working in a silo (or a group of these). For if the individual healthcare professionals can deliver their service within an organised framework, knowing what specific services were being provided to patients from other parts of the system in their local geography, then this is likely to result in much better outcomes for the patient.

Any new system must not only improve the collaboration between pharmacists working in the different sectors, but crucially, it must integrate with GP practices and other disciplines across the whole of health and social care. The creation of a community of practice would enable doctors, pharmacists, nurses and other healthcare professionals (most still based in their existing locations, others as a mobile or virtual resource) as well as Social Care specialists across all sectors to apply their unique skills collaboratively, so that they can achieve joint objectives in a much more efficient and joined up way.

Collaboration, coordination and innovation would be the hallmarks of this new emerging healthcare system. Space does not permit a detailed proposal in this regard, but a change of role for the community pharmacist through pharmaceutical care and triage and the community pharmacy as the most accessible physical place for initial patient presentations provides the lynch pin for a paradigm shift.

Delivered by a locally managed system

A key component of this service redesign is the premise that the local needs of patients are best understood by the locally managed system. This concept was demonstrated during Covid, when local towns were given control of their own infection control measures, showing the local control approach to handling Covid hot spots to be far more efficient than a much more problematic and expensive national lockdown situation. In such a local approach, if pharmacy could be integrated more widely throughout the health system and, if patients could present first to the local community pharmacy, then success could be measured by metrics that are far greater than just how much extra capacity can be given to GPs.

The current healthcare structure does not allow for the coordination of the work of pharmacists, GPs and others across different settings such as hospitals, GP surgeries, care homes or community pharmacies. With a degree of coordination, this problem can be addressed driving considerable benefits for the healthcare system generally and for patients specifically.

A local primary care organisation, (such as an ICS or Health Board), must operate at the centre of this more comprehensive 'locally managed system'. It has a comprehensive and unique 'helicopter view' understanding of the wider population health and health economy related challenges facing the local geographical areas that it serves. It, like the conductor of an orchestra, is best placed to marshal the available financial and intelligence resources.

Through commissioning, it can ensure that the efforts of all the doctors, pharmacists, nurses and others

working in a variety of settings in the locality can be coordinated and integrated into the wider healthcare system. It can go a long way in supporting the creation of an integrated community of practice. These locally managed systems would recognise that the needs of one local community will be different from that of another. It would be the local primary care organisation which would work out what the local priorities should be and how they should change over time to reflect local needs; it would be best placed to commission joined up services.

For example, in communities with former mining or heavy industry history, the prevalence of patients with respiratory conditions might be best served by a pharmacy service for COPD patients to help redirect patients away from GPs and acute care.

Advantages

- A multi-agency approach involving healthcare, social care and public health.
- Understanding local population health and health economy related challenges.
- Using risk stratified data and health needs assessments to align services to local needs.
- Prioritising the services most needed locally.
- Development and management of tailored interventions for consistent delivery at scale resulting in reducing inequality and variation.
- Local (co)commissioning of community pharmacy services.
- NHS personnel working hard AND working Smart; utilised to much better effect.
- Releasing significant overall capacity for the NHS.

Changing working practices

- A far greater reliance on shared read/write patient data.
- Primary care providers working as a multidisciplinary team
- Local healthcare intelligence and needs assessments fed into service delivery models.
- Services provided will vary nationally as they will partly be driven by local priorities

Changing workforce roles

- As already described community pharmacy would become the 'First Port of Call' for the NHS requiring pharmacists to be present and available for walk in presentations without appointments.
- NHS personnel would be working much more collaboratively under a system managed locally, increasing efficiency, reducing waste and dramatically improving the patient journey.
- Using the c13,000 community pharmacy locations in the UK far more productively than is currently the case providing patients with far more accessibility to the NHS.

Case study

The local Directorate for Public Health has identified that certain suburbs in their city have a problem with high levels of diabetes and pre-diabetes. The primary care organisation uses the public health and hospital data to identify the specific hot spots and tasks the local 'Community of Practice' with improving outcomes.

Community Pharmacies would utilise their knowledge of the local population and language skills to participate in education and testing initiatives which would identify pre-diabetes in target groups. They would then direct patients to specialist local dieticians and provide lifestyle support.

The community pharmacies would also ensure regular monitoring of diagnosed patients, manage caseloads of registered stable patients, train patients on injection technique and improve outcomes. Under this system, poorly controlled patients would be referred on to GP practice-based pharmacists and if severe would be managed as part of a virtual multi-disciplinary team exercise supported by GPs with a special interest in diabetes and diabetologists if necessary.

The result is that fewer pre-diabetic patients progress to diabetes and there is better control of already diagnosed diabetics. Payments for the 'community of practice' (community pharmacies and general practices; or Healthy Living Centres) in designated areas are based around joint achievement of patient outcomes.

3. Hospital Discharge Service

Historically, many issues emerge because of a poor focus on this area; a classic example of silo working. Many of the claims for compensation handled by the PDA have at their root cause a hospital discharge process which causes confusion and uncertainty in primary care.

Patients are often discharged from hospitals with either complex medicines regimes or sometimes with subtle changes to their medication regime which may only be required on a temporary basis. The hospital discharge letter, which is sent to the GP, often lacks the detail to ensure that the patient's discharge into the wider community is successful. The implications relating to ongoing supplies of medicines and the wider support service provided by the community pharmacy rarely features in the hospital discharge process.

The result of this silo working is a poor patient journey with many being unnecessarily re-admitted which dramatically increases the costs to the NHS. In 2017/18, there were 865,625 emergency readmissions, the highest figure recorded to date, up from 756,020 in 2013/14 (NHS Digital, 2019), an increase of 1.3 per cent from 12.5% in 2013/14 to 13.8% in 2017/18 (NHS Digital, 2019). The cost associated with hospital readmissions in the UK was estimated at £2.2 bn each year.

A hospital based primary care medicines liaison role could be created to support safe and effective hospital discharge and into the wider community.

Simplifying the hospital discharge process through use of Electronic Prescribing and Medicines Administration (EPMA) systems, could see medication to take home (TTO) to be requested electronically and dispensed from a convenient community pharmacy for the patient.

This would not only smooth out any unnecessary delays and free up bed occupancy but could trigger a pharmacist led support programme of pharmaceutical care to aid the transition with a view to preventing re-admission.

Advantages

- Improving the efficiency and effectiveness of the healthcare system by reducing silo working and removing the operational barriers between primary and secondary care.
- Reducing the risk of Adverse Drug Reactions, iatrogenic disease and the costs of unnecessary medicine.
- Improving the patient journey in an area which is classically in need of repair.
- Reducing unnecessary workload by increasing the understanding of discharge related medicines issues at the GP surgery, the community pharmacy and the care home.
- Avoiding unnecessary hospital re-admissions.
- Supporting team working within the NHS

Changing working practices

- ICSs create multidisciplinary teams that assume overall and total care responsibility for discharge and clear pathways for discharge and all subsequent intervention points.
- The teams would involve pharmacists (with a range of skills – for example those with experience with elderly and frail patients), but may also involve others such as paramedics, and occupational therapists to be able to handle any wider discharge related issues. A pharmacist would be embedded in the hospital to oversee and manage the discharge process to ensure that all necessary specific discharge information has been passed to the primary care service and, where required, has been referred to appropriate outpatient team.
- In the UK, the Australian model could be followed whereby hospitals arrange for specific HMR (home medication review) with accredited pharmacists visiting the patient at home or in their care setting. This could form the basis of a model where the pharmacist (as part of a wider team) is the central point of contact to co-ordinate medications between hospital-community pharmacy and GP.
- Experience in Wales suggests that GP reluctance to engage in the Discharge Medication Review (DMR) process may need incentivising by inclusion as a metric for QOF calculations.
- Community pharmacies would be drawn into the wider healthcare team for the benefit of the patient.
- Pharmacists as the medicines related experts would work significantly upon the administrative arrangements related to the use of medicine by 'higher risk' patients.
- Pharmacists would have a greater operational influence over the patient's medicines related experience.

4. Community nursing referrals by pharmacists

The pharmacist working in community or GP practice could identify patients in need of community nursing support to enable them to continue to live safely in their own home. As part of a multi-disciplinary team, they could provide an essential link to referral pathways for community nursing and social care service teams, identifying cases early and improving integration with wider health and care provision.

Building on the Healthy Living Pharmacy model, community pharmacy teams would include a trained champion who could support the navigation of care around independent living and mobility aids for example.

GP surgeries in many parts of the country can rely upon a support service for those 'frequent flyer' patients that are challenging because they have a multiplicity of problems which may not all be purely medical, but possibly also social and which may be accompanied by various complications e.g., they might be housebound or disabled.

The GP practices can refer such patients to a locality service; usually headed by a 'Community matron/ District Nurse team'. These are individuals who may visit the patients and invest a considerable amount of time in resolving their various and perhaps more time-consuming issues.

Currently, the community pharmacy is not part of the community nursing referral system. It is proposed that the community pharmacy service can become an active participant in this District Nursing (DN) and Community Matron scheme and that it too, through formal pathways is able to refer patients to it.

A more collaborative approach involving the Community Pharmacist would help reduce pressure on the primary care system and because it would help to handle issues earlier on in their genesis, it could also contribute to a reduction in unnecessary hospital admissions. Access to GPs advice via remote help or referral to the community matron service should be available if the nature of the query is beyond the scope of the community pharmacy based independent pharmacist prescriber.

Advantages

- The UK has high levels of unplanned hospital admissions especially associated with elderly patients. Community pharmacy referrals directly to the DN/Community Matron service would result in more timely access to dressings, appliances and flag any concerns regarding ongoing treatment being administered in the home.
- Creating a referral link would also help reduce GP workload if DNs or Community matrons were also able to refer patients to the community pharmacy (rather than the GP practice) to deal with medicines related issues or minor ailments (e.g. Provision of head-lice treatment for care home residents).
- Community pharmacist will be able to play a greater role in management of those patients with multiplicity issues thus saving precious time of the GP Practice and embedding community pharmacy further into the wider NHS.

Changing working practices

- The Community pharmacy would be seen as a first line contact for District Nurses for dressings, appliances and medicines advice. This would ultimately necessitate access to the patient's medical history, blood results etc. and read, write access to patient's personal records.
- The pharmacist would be seen as an essential link to referral pathways for District Nursing / Matron service teams enhancing the incorporation of community pharmacy into the wider NHS framework.

- Through its greater focus on clinical issues and integration with the wider primary care service, the community pharmacy would begin to look more as an accessible important referral pathway for patients with multiplicity of problems rather than as a shop.
- At present some primary care organisations have Older Patients Specialist Pharmacists (OPSP) on their teams. These pharmacists could integrate with Matrons, and support community pharmacists to provide better care such as, medicines reviews for falls prevention, promoting the prevention of "avoidable harms" such as pressure ulcers and urinary tract infections in patients with catheters.

Changing working practices

- Elderly and Care Home residents are recognised as having increasing demands due to multifactorial health care needs as life expectancy increases. This is an opportunity for Community Pharmacists to gain more specialist knowledge and understanding of the medicines related issues regarding Elderly Care and become more familiar with the issues faced by elderly, Care Home staff and areas of care that Matrons take responsibility for.
- Staff at the community pharmacy would be trained to understand how delivery of this service and support thereof could be met, like certain staff taking responsibility of tray patients in care homes. Those staff would be able to come to understand much more about the medicine issues, out of stocks, referral process for help and the need to maintain relationships with surgeries.
- Better, IT enabled communications in particular the full patient record would support greater visibility of the treatment plans for individuals in care homes
- Care home staff could be supported with training to provide a co-ordinated approach to ordering medicines or notifying of changes to medicines to improve efficiency and safety.
- Primary Care Organisation based Older Patient Specialist Pharmacists (OPSP), can lend support to this service enhancing the patient care pathway from appointment/ medical issue to resolution in conjunction with the community pharmacist.

Case studies

1. A District Nurse conducting home visits for an elderly patient in their own home tasks the local community pharmacist for a prescription for supplies of the appropriate dressings. The request would be prescribed and issued by the community pharmacist prescriber and a supply would be delivered to the patient at their home in a timely manner. Stocks of approved and agreed dressings are ordered directly from NHS supplies to ensure efficiency in the supply chain.
   The Community Pharmacist makes an entry into the patient's record that a supply has been made as per the District Nurse request, and if any further intervention is required beyond the scope of the community pharmacist, then this could be flagged to the GP/PCN Pharmacist/ANP or Nurse.

2. A Community pharmacist identifies an elderly patient coming in for a prescription for medicines designed to manage diabetes. The pharmacist engages the patient and ultimately identifies that the diabetic patient's Blood Pressure is raised and that the patient had not had a diabetic foot check in the past year and is experiencing 'pins and needles'. The pharmacist contacts the District Nurse/Community Matron service and refers the patient for a blood pressure check and a diabetic foot check to be delivered at their home.
   This referral pathway will be especially helpful with those patients who are 'hard to reach' or frequent non-attenders at their GP practice.

5. Social care champions in community pharmacy

Using the same approach as taken in the Healthy Living Pharmacy initiative, the service could be delivered initially through opportunistic interventions during existing pharmacy services. All pharmacy staff would be trained to understand the broader issues and local referral pathways to access social care services. Additionally, each pharmacy would employ one specifically trained Social Care Champion; possessing a much more detailed knowledge of the local Social Care situation, connected to the local networks, capable of providing leadership and handling the more challenging cases that present or that may be referred from less experienced pharmacy colleagues and elsewhere.

Pharmacies would become an accessible and initial contact point for members of the public who have needs that may require social care as well as those requiring additional support for pre-existing conditions such as physical disability.

The Social Care Champion could be on hand, working from their own room in the pharmacy (possibly a consultation room) to resolve issues directly or to sign post and use referral pathways where necessary. They would take ownership of a list of cases built up through walk ins, hospital discharges and referrals from GP's and District Nurses, delivering bespoke benefits to meet the patient needs.

Advantages

- There are over 13,000 pharmacies in the UK, found in the heart of communities making them very accessible for most of the population.
- No appointment necessary and with much longer opening hours- patients and their carers can speak to a member of the pharmacy staff or if necessary to a trained Social Care Champion, who would either be able to support and handle their enquiry or sign post them onwards to a more appropriate service provider. This could deliver benefits and improve access for families and patients.
- Pharmacies would be able to refer patients to social care networks in a way that GPs currently do, enabling GPs to focus their work on acute presentations and/or the more complex cases.
- Easier, faster referrals where necessary, working to ensure that patients do not drop through the cracks. Ultimately reducing unnecessary hospitalisation and the associated costs to the NHS.
- Some pharmacies already stock a range of social care aids such as mobility aids, others would follow suit if this service were adopted.
- Patients would have a clearer view of an integrated health and social care service accessible at the point of need.
- Improving the link between health care and social care.

Changing working practices

- The community pharmacy becomes an established member of the Social Care service becoming a significant community resource; this re-enforces its first port of call positioning.
- The community pharmacy is positioned as a provider of accessible health and social care advice and less like a shop.
- Local Social Care leads to support the governance, quality and training arrangements in the pharmacy and supporting the Social Care Champion to

reduce inequality and variation.

- Increased collaboration between pharmacy teams and the wider health and social care network, improving patient outcomes.
- The pharmacy could also support residential and care homes in the local area.
- Pharmacies could also engage with hospitals and GP practices to support any discharge issues.
- Pharmacy personnel take an active interest in any patients presenting opportunistically that may have potential problems requiring wider social care solutions.

Changing workforce roles

- The pharmacist will lead an extensive team of individuals each trained to deliver more specialised services.
- All members of staff are familiarised with the local Social Care mechanisms.
- One member of staff specialises in social care and is the main driver of the service.
- Increased focus on building up an integrated health and social care network within the local area to facilitate efficient signposting and support of patients when they need it.
- The Social Care Champion becomes a community resource, with up-to-date information on the referral processes and developments within the social care pathway.
- Social care champions form networks to facilitate service provision for local minority ethnic groups. For example, building up local banks of translators to overcome language barriers.
- A dedicated social care champion would give flexibility and potential for domiciliary care for housebound patients.

Case study

Mrs Smith, 66, lives alone and has multiple co-morbidities including osteoporosis and takes an average of 12 medications. She visits her local pharmacy to buy pain killers and the pharmacy counter assistant notices that she is struggling to walk and asks why the pain killers are needed. Mrs Smith explains that she is in agony because she slipped at home and injured her ankle.

The counter assistant suggests that Mrs Smith sees the 'in pharmacy' social care champion to consider whether anything can be done to make her life easier at home. During the consultation, it transpires that this is the second time she has slipped at home and that she does not have any mobility aids.

The Social Care Champion coordinates with the (community pharmacy based) pharmacist who undertakes a medication review which identifies no major issues in relation to the patient's medication regime. The social care champion discusses the different options of mobility aids with the patient. A referral is made to an Occupational Therapist to visit Mrs Smith at home and assess her needs and provide suitable adaptations.

She is also able to refer the patient to the appropriate social care service to be reviewed for a fall detector or motion detector to avoid any similar incidents or potential hospital admission due to falls in the future. The pharmacist records the result of the medication review and any new arrangements provided on the patient's medical record to be available for other healthcare professionals involved in the patient's care pathway.

6. Technology Hub – increasing access to NHS for the digitally disenfranchised

Digital technology is increasingly being used to deliver services by the NHS, however, many patients are still not digitally enabled potentially leading to inequality. Pharmacies are convenient and recognised health and well-being hubs which could, with appropriate funding and premises, support digital inclusion by providing access to communications devices and the internet, enabling patients to engage with other parts of the NHS in a virtual way and improve health literacy.

This proposal builds upon the premise that the community pharmacy becomes the locally and immediately accessible primary care technology hub and the fact that much of the primary care service will increasingly be made available via remote means in the future. The community pharmacy would become a link to the wider NHS virtual system (be it the GP, community nurse, hospital or other yet to be established virtual arms of the NHS) providing the hands-on support and the leadership needed to show members of the public how to navigate these new virtual services.

Expanding access beyond traditional face to face consultations with a GP poses challenges for some groups of patients who may not have home computers or internet connections, moreover, they may not be familiar with technology. Community pharmacies are ideally placed to not only increase access to the broader NHS and Social care services through virtual means by providing the infrastructure, but more importantly, to provide the personnel to act as the patient's champion in supporting and facilitating their efforts to engage with the new NHS technology led revolution.

It has been established that groups with limited access to computer technology are largely the same as those suffering the greatest health disparities and traditionally underserved by the healthcare system (Eng et al, 1998). This service goes some considerable way in reducing this inequality.

Advantages

- Pharmacies are ideally placed to offer quick access to patients who cannot navigate the digital access for healthcare, elderly or patients who cannot afford home internet.
- The coronavirus pandemic has accelerated the growth of telemedicine at an unexpected rate.

With stay-at-home orders and social distancing efforts, it has been necessary to visit speak to GPs via video/telephone link, and as a result NHS is ever more prepared for virtual appointments.

- A much greater reliance on virtual meetings in the NHS could be facilitated via community pharmacy for those unable to do so from home.
- Referral links could be set up for patients to gain access from their community pharmacy to a wide range of health care advisors/professionals via virtual appointments. These could include:
    - Dietician
    - Smoking Cessation Advisors/ Prescribers
    - Reducing the burden of chronic disease through wellness and prevention and education advisors
    - Physiotherapists via virtual appointments to triage for further face to face assessment, referral for scans or x-rays, or ongoing treatment
    - Family Planning virtual appointments
    - GP/Community Nurse/Matron/ Hospital

- Community pharmacy to promote and introduce patients to counselling or education sessions with groups of other patients with similar health issues for support, e.g., diabetes community, Parkinson's, young carers, renal support groups, mental health sessions.
- Virtual appointments with a Clinical Pharmacist for medication reviews for patients with LTC. This will support GP practice/ PCN/ICS pharmacists.
- NHS generally to be able to handle many more virtual consultations.
- Referral pathways could be booked virtually and in real time.

For this to work, part of the community pharmacy could be designed to enable confidential use of the internet.

Changing working practices

- Community Pharmacy begins to be seen as an important health resource rather than a shop and is seen as the essential link to various referral pathways for patients thus enhancing patient accessibility through virtual appointments/ telehealth.
- As primary care organisations reconfigure, they must have regard to the need to reduce inequalities that can be caused by an inability by some patients to engage with digital platforms.
- Patients to register with pharmacy of their choice to gain access to virtual appointments or referrals.
- Community Pharmacy and GP practice to work collaboratively to facilitate quicker and greater access to wider NHS and social care departments for their patients.

Changing workforce roles

- Members of the community pharmacy team are trained to support patients in accessing the NHS remotely. This could involve setting up the virtual appointment and helping patient navigate the IT to link patient with appropriate health provider in the consultation room.
- A nominated member of staff (who may be the lead driving force for the service) to triage the consultation to help patients move through the service.
- Wider NHS and Social Care staff encouraged to receive virtual appointments / consultations.
- Second clinical pharmacist available to handle emerging issues related to pharmaceutical care.
- IT infrastructure must be in place to enable community pharmacy to view virtual appointments/ telehealth slots for patients requiring access.

Case study

An elderly patient regularly uses her community pharmacy to order her incontinence appliances. The same type of appliance has been used by patient for several years without an appliance use review being noted for the past 2-3 years.

The pharmacist / trained member of staff identifies this need and discusses option for patient to have a virtual appointment with a nurse that specialises in appliance use, such as a Continence and Stoma Prescribing Specialist nurse. The patient agrees and the trained staff member proceeds to book a virtual appointment for the patient at a convenient date and time in the pharmacy.

The patient attends for the pre-arranged appointment and the consultation link is set up between the nurse and the patient in the consultation room. The pharmacist is then on hand to join this meeting and if necessary to facilitate any emerging issues with the consultation or help obtain a new incontinence product that the nurse may recommend. A prescription can then be generated by the prescribing pharmacist, and the patient's records are amended accordingly, (or the GP is sent details of the transaction for their records).

The nurse during the consultation, may decide/arrange a home visit to the patient. The community pharmacist is available at any point to help with the continued care for patient.

7. Supporting the national obesity strategy; especially in children

In addition to established smoking cessation and cardio-vascular disease prevention, pharmacists and their teams could spearhead other public health campaigns. Reducing levels of obesity is a service that can be delivered in a community pharmacy both opportunistically and as part of a managed service.

Statistics indicate that 1 in 4 adults in the UK are obese with a further 62% being overweight, making the UK the most obese nation in Europe. These figures have been rising over the last 2 decades and are also likely to be the cause for the increasing levels of Type 2 diabetes. Poor diets and an increasingly sedentary lifestyle are often to blame.

The problem is increasing due to high levels of obesity in children. NHS reports indicate that 1 in 5 reception age children are now obese, rising to 26% of children by the age of 11 (year 6). Obesity levels are highest among those children from deprived communities with year 6 levels of obesity at 12% in the least deprived areas. Statistics also indicate that overweight and obese children are most likely have parents with similar weight problems.

A government campaign has been launched to encourage weight loss, because it was recognised that Covid-19 puts those who are obese at greater risk of death or complications. The added complications of obesity such as diabetes, stroke, cancers and heart attacks are also adding considerable strain to the NHS and reducing the life chances of an increasing number of the population.

Currently, when children are weighed at primary school (as part of the National Child Measurement Programme) their parents are sent a letter advising them of their children's weight and whether they are in the normal range, obese or underweight for their height and age.

An example of the current inefficient system is that currently, there is little (or no) follow-on support for these families to actively participate in a weight loss and healthy eating programme. Some pharmacies have had an initiative to support families in these circumstances where the Year 6 children and their families are referred to the local pharmacy for a weight loss programme, but this is not available at scale.

Community pharmacy could become the recognised hub for supported weight loss management, especially for families and children.

Advantages

- A nationally recognised initiative to support weight loss and healthy living, especially amongst children.
- Accessible on the High Street and enhancing the reputation of community pharmacy as a health and care service not a shop.
- Helping to meet government targets to reduce overall obesity.
- Delivering the support mechanism for families who receive the letters in reception and year 6 that their child is overweight or obese. The pharmacy could provide weekly weigh ins and record the weight, advising on diets, lifestyle and health. This would encourage the whole family to be part of this programme if appropriate, not just the child.
- Where appropriate community pharmacy could sign post to and collaborate with other organisations, such as Weight Watchers or Slimming World.
- Community pharmacy could work with GPs to refer appropriate patients into the weight loss programmes, linking with dieticians and nutritionists.

Changing working practices

- A member of the pharmacy team to be the designated weight management champion and each to be trained to specifically support children and young people. This person could be the Healthy Living Pharmacy champion.
- Currently, the communications received by parents of obese children do not provide a specific support mechanism, only advice and links to information. A monitored programme in the local community pharmacy is likely to have greater impact.
- Pharmacy teams could work with local primary schools through out-reach initiatives to explain the programme and reduce any concerns about taking part.
- Pharmacy employers could be encouraged to make their weight loss programme available to members of their staff and their families.

Case study

Natasha has received a letter from the community health trust with the results of the height and weight measurements of her daughter Evie aged 11. Evie is classified as being obese for her height and weight.

The letter gives her a named person to contact at her local pharmacy who will support Evie and her family to take part in a 12-week programme to lose weight and get healthy. The contact at the community pharmacy is a Healthy Living Champion.

Evie will be weighed weekly and given a diet programme prepared by nutritionists. She will also be given vouchers from the local authority to access local swimming pools and fitness centres for free during the programme.

The whole family will be encouraged to take part as Natasha is also worried about her weight and was recently diagnosed with diabetes. At the end of the 12 weeks Evie and her family will emerge at a healthier weight and possess the confidence and knowledge to make healthier lifestyle choices going forward.

8. Providing opportunistic services whilst delivering vaccinations in pharmacist led community vaccination hubs

With far more patients understanding the importance of influenza and Covid-19 vaccinations, pharmacist involvement in large-scale vaccination programmes is set to continue especially as living with Covid-19 becomes a normal part of life. One innovation that was developed during the Covid-19 crisis was the creation of pharmacy led vaccination hubs in the community. This meant that pharmacists could dramatically scale up their service enabling them to play such a very significant part in the successful delivery of the vaccination programme in England and Wales.

With the majority of Covid-19 vaccinations in primary care being delivered by pharmacists in this way, it is highly likely that the pharmacist led vaccination hubs will continue to be operated into the future.

With the prospect of many hundreds of people attending pharmacy led hubs for vaccinations each day and each hub representing a healthcare facility in its own right, there is the possibility of reaching many millions of people with health improvement and prevention initiatives. By providing additional opportunistic interventions, including health checks, diagnostic checks and even ordering blood monitoring for patients who have not had their bloods analysed whilst taking medicines that require them to do so, the NHS can maximise pharmacists to make every contact count.

By using such an opportunity for wider effect, pharmacists could contribute to the reduction of the long waiting list of outstanding diagnostic tests and other urgent procedures where the NHS has latent need. Through the integration of these activities with other parts of the system through referral and other reporting, pharmacists can have a significant impact on the prevention of avoidable illness and reducing health inequalities. This is another example of how a local primary care organisation can establish local priorities and provide the added protection of oversight and operational support.

Advantages

- Addresses the backlog of preventative screening services which has developed because of Covid-19.
- Maximises the opportunity of large numbers of the population attending vaccination hubs by engaging people in a wider range of public health / prevention initiatives for example stop smoking.
- Helps to tackle health inequalities through opportunistic interventions / referrals.
- Accessible venues in the heart of local communities.
- Local health priorities can be channelled through hubs to target cohorts suitable for referral or screening – referrals could be to community pharmacy or other NHS providers.
- Enables the identification of previously undiagnosed conditions, which may have otherwise been missed, supporting improved patient outcomes and NHS sustainability.

Changing working practices

- Adaptations to the pre-vaccinations checks and consent process to include possible screening / onward referrals.
- Pharmacists operating as clinical oversight, supervising and interpreting results and referrals
- Diagnostic equipment required to deliver basic screening and diagnostic services.
- Training of vaccination hub staff to support the screening / interventions.
- Connectivity to enable reporting of results or referral to other parts of the system where patients are identified for checks outside of those provided at the hub.
- Privacy of a consultation area to allow for discussion and screening to take place.
- Local health organisations to direct priorities.

9. Diagnostic testing to support public health

Diagnostic activities do not need to be restricted to the pharmacist led vaccination hubs, as opportunities also exist to deliver some of these in a regular community pharmacy setting albeit in a slightly different way.

Recent developments around screening and referrals have been announced, particularly around the early detection of cancer through the identification of red flag symptoms so as to support the 2-week wait cancer pathway.

There are opportunities to develop a range of diagnostic testing services in a community pharmacy setting to help manage capacity in other parts of the system, particularly in other parts of primary care.

The NHS estimates that 1 in 4 GP appointments are avoidable, owing to the symptoms being very minor in nature and treatable with over-the-counter medication. Overstretched capacity does not allow time for sufficient diagnostic tests. One consequence of this is a 6.5% increase in antibiotic consumption over the 4-year period from 2010 to 2014 in England with many patients being inappropriately prescribed antibiotics for simple coughs and colds, sore throats and ear infections

Diagnostic tests from within the community pharmacy setting which possesses the space and expertise required to offer a diverse range of services to reduce the burden on other primary care providers. A structured programme of tests which could be conducted which looks at a much wider range of conditions.

As we move towards more personalised medicines, pharmacists could be involved in assessing the suitability of patients for treatments through pharmacogenomics screening.

Advantages

- Early intervention and/or referral where necessary would improve the patient journey, reduce pressure on GP surgeries and reduce costs to the NHS.
- Reduction in unnecessary prescribing of antibiotics and antimicrobial resistance.
- Pharmacies stock a variety of P or GSL medications which can assist with self- care, upon diagnosis.
- Agreed formulary medicines supplied under a PGD or simply prescribed by a pharmacist.

Case study

Ivan works as a headteacher and the school has public exams coming up, so he is very busy and unable to take time off. He is feeling unwell but knows that it is difficult to get an GP appointment at a time when he can attend and relies instead on the well-advertised and much more convenient walk-in diagnostic testing service at his local community pharmacy.

He presents at the pharmacy for a consultation with the pharmacist after school hours, he has classic Respiratory Tract Infection symptoms, such as runny nose, headache, muscle aches, tight chest, and fever.

Ivan knows all about the problems of unnecessary antibiotic use and when the pharmacist carries out a simple C-reactive protein (CRP) test, the levels are shown to be low, indicating a viral respiratory tract infection rather than a bacterial infection which may have required treatment with antibiotics.

The pharmacist talks Ivan through his over-the-counter treatment options for his symptoms and gives self-management advice to help him recover. He is relieved that he has been tested and that an appropriate course of action can now be determined without the need for unnecessary antibiotic use, thus reducing his risk of tolerance to them when he really needs them.

10. A 'patient-facing pharmacist' using the prescription presented at a community pharmacy as an opportunity to make a clinical intervention.

Using a Population Health approach

Community pharmacists work at the very front line of patient care and see more than 1.6m patients each day in England alone. Every time a patient comes in to collect a prescription, the pharmacist carries out checks for legal and clinical appropriateness before making the decision about its suitability. Research[15] has indicated that as many as 1 in 8 prescriptions issued by a GP surgery contain an error.

With better access to the full patient record, the prescription provides a valuable opportunity to look at the holistic medicines use of the patient, and to address any underlying pharmaceutical care issues. In a two-pharmacist operating model, the 'front of counter' patient facing pharmacist could carry out these vital interventions. The PDA has identified a list of several dozen red flags which indicate where a problem with prescribing may have occurred. Some of these are very simple and others more clinically complex. In such a service, the local primary care organisation could prioritise the specific interventions that the patient facing pharmacist should look out for in a specific area and deliver a pre-agreed range of remedies. The opportunity to engage vulnerable or at-risk patients in national vaccination programmes could also be implemented.

Advantages

- Collaboration and integration delivered with the support of the primary care organisation.
- Patient facing pharmacists can play a key role in population health by supporting clinical governance and identifying and acting upon inappropriately prescribed medications.
- Delivering a positive health benefit to the patient through not taking unnecessary medication.
- Anti-Microbial Resistance (AMR) stewardship
- Avoidance of harm caused by overprescribing.
- Delivering a health economic benefit on the overall medicines budget and preventable interventions or hospitalisation.
- Developing skill mix in the pharmacy.
- The pharmacy is seen as more of a clinical centre and less as a shop.

Changing working practices

- Local primary care organisation to establish and support the local priorities.
- Using the prescription to not only order the required medicines but also to identify opportunities for clinical interventions.
- Opportunistic interventions are sought at the time the pharmacist makes a clinical assessment of the incoming prescription.
- Pharmacist engages with the patient and has a wider conversation about seeking to make the interventions.
- Pharmacy technicians would need to take charge of the assembly of prescriptions.
- A two-pharmacist pharmacy would provide the clinical critical mass need to support such a model.

A 'patient-facing pharmacist' using the prescription presented at a community pharmacy as an opportunity to make a clinical intervention.

Case studies

Use of high dose Aspirin for a duration longer than one month in a patient aged over 65 years

According to the BNF[16], doses of Aspirin over 160mg should have the STOPP (screening tool of older persons prescriptions) criteria applied, owing to an increased risk of bleeding and lack of evidence over the efficacy using a higher dose. High doses of Aspirin always catch the attention of a pharmacist during the clinical checking process, and so they would be ideally placed to deal with this issue at the point of patient collection or during the dispensing process.

Using steroid eye drops for longer than two weeks

In the vast majority of circumstances, steroid eye drops are prescribed to treat redness or inflammation in the eye for a short period, usually for no more than two weeks. Surgery repeat prescription systems, have resulted in many patients continuing to receive unnecessary repeats for their steroid eye drops. Used in the longer-term, steroid eye drops lead to the development of cataracts especially in the elderly. A red flag for a patient facing pharmacist regarding longer term use of steroid eye drops may result in the summary stoppage of the steroid eye drops following initial inquiries. Hence reducing the risk of cataracts.

Long-term prescribing of amitriptyline to frail elderly patients:

According to the BNF, elderly patients are particularly susceptible to the side effects associated with tricyclic antidepressant use; particularly cardiac and psychiatric effect. As elderly patients only occasionally visit their GPs (either for annual reviews or to deal with an acute situation), there are not many opportunities for GPs to deal with this potential harm. The patient facing pharmacist could be tasked to detect and act upon such a prescribing pattern within the framework of a locally agreed protocol.

Concurrent use of two non-steroidal anti-inflammatory drugs (NSAIDs) for a duration of over two weeks:

NICE guidelines state that NSAID use can be associated with gastrointestinal side (GI) effects, along with effects on renal and hepatic systems and bronchospasm. These effects are cumulative, so the use of two NSAIDs concurrently for a period greater than two weeks could cause harm to patients who are elderly or suffer several co-morbidities. Pharmacists can identify cases where multiple NSAIDs have been prescribed for a period greater than two weeks and act upon such a prescribing pattern within the framework of a locally agreed protocol.

Identification of patients with a risk of Acute Kidney Injury (AKI) and counselling around medicines use:

AKI is associated with a fifth of hospital admissions in the UK and with up to 40,000 excess deaths . Patients who are elderly and/or have chronic kidney disease (CKD) who are prescribed non-steroidal anti-inflammatory drugs (NSAIDs), ACE inhibitors or angiotensin receptor blockers (ARBs) can be at higher risk of developing AKI. This risk can be significantly increased and can result in development of AKI and hospital admission if the patient becomes dehydrated for any reason. Patients on these medications should therefore receive advice and guidance about what to do should they develop an acute illness which may make them dehydrated such as diarrhoea and/or vomiting. 'Sick Day Rules' guidance is available for these patients to guide them through stopping their medication whilst ill to avoid them becoming dehydrated. This advice would be offered by patient facing pharmacists upon the receipt of a prescription which fits this profile.

[15] GMC – Prevalence and causes of prescribing errors

[16] British National Formulary

[17] NICE Clinical Knowledge Summaries

[18] Research - Identifying on admission patients likely to develop acute kidney injury in hospital

11. 'Clinic Pharmacist' delivering more effective management of patients with long term conditions.

Long Term Conditions (LTCs) account for 50% of all GP appointments[19]; 70% of all hospital bed days; and 70% of health and care expenditure. There are 36 million people with one or more LTCs. Pharmacist involvement in supporting patients already diagnosed with LTCs would lead to improved outcomes for patients and an increase in the capacity of the GP service.

Substantive proposals within this paper are predicated on the fact that there are at least two pharmacists available in the pharmacy. One of these would be patient facing – dealing with the opportunistic interventions that present themselves by incoming patients without an appointment (point 10).

The second pharmacist would be a 'clinic pharmacist' working to provide the longer-term pharmaceutical care of registered patients, those referred by GPs who they have previously diagnosed with a LTC. Such a referral would rely on collaboration, creating capacity for GPs to focus on the more acute presentations, delivering virtual wards and reducing unnecessary A&E visits and avoidable hospital admissions.

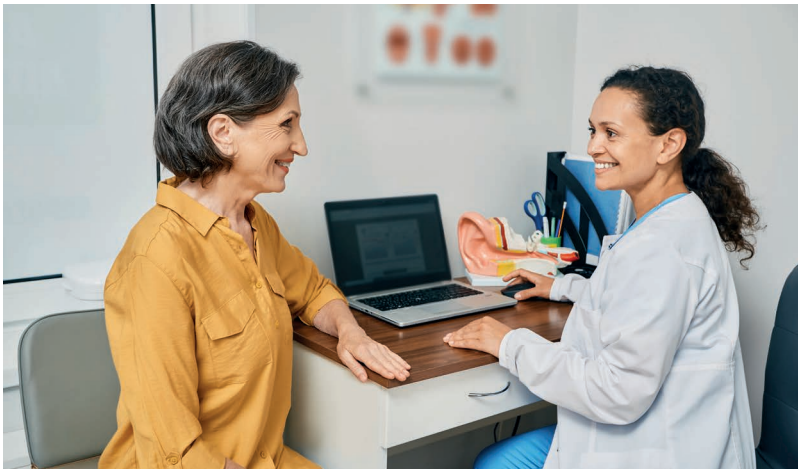
The proposal is that a patient is diagnosed as having a long-term condition by the GP or hospital is referred by the GP to a community pharmacy clinic or is at least given a choice to have their pharmaceutical care managed by a pharmacist in the surgery or in the community pharmacy clinic. The patient is formally registered with the service.

Advantages

- Better management of GP appointments and releasing GP capacity.
- Improved access to healthcare for patients.
- GPs able to focus upon acute presentations, virtual wards and reducing unnecessary A&E visits and avoidable hospital admissions.
- Patients get a pharmaceutical care champion; service improved beyond current arrangements with continuity and convenience.
- A focus upon the correct use of medicines, with a treatment plan agreed with the patient.
- Reducing waste and harms caused by interactions or adverse drug reactions.
- Direct proximity between the clinic and the patient facing pharmacist and the pharmacy technician would lead to improvements in communication between the supply and the prescribing function.
- A 'clinic' and 'patient facing pharmacist' approach would help to create a structured clinical skills escalator and career framework in community pharmacy.

Changing working practices

- Consultation room in the community pharmacy used to deliver pharmaceutical care.
- Service led by referral on an appointment led basis.
- A healthcare team is built in the community pharmacy enabling it to become recognised as more of a healthcare facility and clinical hub and less so a shop.
- One 'clinic pharmacist' could service the needs of several pharmacies in the locality depending on the number of appointments.
- The 'Clinic pharmacist' could receive trend data as well as clinical support from the local primary care organisation.
- The 'Clinic pharmacist' could receive virtual support from GPs working at the primary Care organisation hub if required.



[19] NHS England – Making the case for the personalised approach

Case study

Nina has been a diabetic for 35 years and takes six medicines for her diabetes and blood pressure. She has also been diagnosed with Chronic Obstructive Pulmonary Disease (COPD)

Following a hip replacement, Nina is also taking pain relief medication which has caused considerable gastric pain, and she has had breathing difficulties and chest infections due to her COPD, resulting in her being recently admitted hospital.

On discharge from hospital, Nina was registered with a clinic pharmacist and attended a couple of pharmaceutical care clinics in the local community pharmacy. The clinic pharmacist liaised with the hospital and GP practice having identified at least one prescribing error as well as a potential adverse drug reaction.

Nina now has a dedicated medicines champion who she regularly meets with the discuss her condition and medication needs. A pharmaceutical care plan is agreed reducing the number of medicines she takes, and the pharmacist discusses 'rescue' medications which should be initiated in the event of the exacerbation of certain COPD symptoms.

Nina now lives in a residential home, but her clinic pharmacist keeps in touch working behind the scenes to make sure that things are kept stable. On one of the regular visits, the clinic pharmacist arranges a talk for residents about diabetes and arranges for a chiropodist to talk about healthy feet. Nina is a lot happier now, is far more aware of her condition and has far fewer worries about her medicines than ever before.

Summary

The Covid-19 crisis has shown how pharmacists and the community pharmacy network can be relied upon to play a much greater role in the wider healthcare ecosystem. These lessons applied in the future can through collaboration create a better integration of the work of GP practices, hospitals and community pharmacies. They show how, because of their expertise and accessible positioning, pharmacists can assist with the delivery of the diagnostic programme, how they can deliver pharmaceutical care to patients previously diagnosed with long term conditions. They also show how patient facing pharmacists can utilise a population health approach to reduce unintended harm caused by medication.

Relying much more so on the connectivity afforded by the use of technology means that the whole healthcare team can be available for the benefit of the patient, even for patients that are not IT savvy, and all done in a facility which is highly accessible. These proposals not only create far greater capacity in other parts of the system, but they dramatically improve the patients journey.

Read alongside the PDA's Wider than Medicines and Road Map proposals, the finer detail of how these developments could be operated are described in more detail as is the proposal for the creation of a group practice of pharmacists and others delivering resilience and clinical capacity in a geographical footprint.

This level of collaboration will not happen organically; the joined-up care being advocated can only be delivered through a Community of Practice which is supported by a locally managed system.

Members of the healthcare team have been working hard and the system is nearing breaking point. The breaking down of the historical silo approach to healthcare commissioning with a focus upon collaboration will enable the NHS to work smarter for the benefit of the NHS, the workforce and ultimately to the patients that we serve.