Response

NHS England

Discussion paper: developing the long-term plan for the NHS

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About the Company Chemists' Association (CCA)

Established in 1898, the CCA is the trade association for large pharmacy operators in England, Scotland and Wales. Our vision is that everyone, everywhere, can benefit from world class healthcare and wellbeing services provided by their community pharmacy.

Between them, our members own and operate over 6,000 pharmacies, which represents nearly half the market and they include ASDA, Boots, LloydsPharmacy, Morrisons, Rowlands Pharmacy, Superdrug, Tesco, and Well. They deliver a broad range of healthcare and wellbeing services, from a variety of locations and settings, as well as dispensing almost 500 million NHS prescription items every year.

The CCA represents the interests of its members and brings together their unique skills, knowledge and scale for the benefit of community pharmacy, the NHS, patients and the public.

Response

The CCA welcomes the opportunity to respond to the NHS long term plan discussion document and we have focused our response in the areas that community pharmacy can particularly support.

Community pharmacy has for some time called for stronger recognition, clearer planning and bolder innovation in how services are funded, supported and enabled to be delivered. Our response takes the opportunity to remind the NHS of what we see as the, as yet untapped, fuller potential of community pharmacy's important role within a wider health and care system. This is to better manage increasing patient need, respond in a sustainable way to increasing long-term conditions and complex and multiple conditions management, and transform the way services are funded and delivered. This is to ensure patients get what they need, when they need it, in a seamless and cost-effective way.

We have also set out some brief case study examples of how community pharmacy is already playing an impactful role in local health economies and indeed nationally, in Annex 1. We think many of these examples could be replicated or scaled-up further across the country.

Introduction

We believe community pharmacy is an integral and progressive part of the NHS which - with the right supporting systems and a sustainable funding framework - is perfectly placed to meet the evolving needs of patients, and to alleviate pressure on the wider health and care system.

We share the vision set out in the Community Pharmacy Forward View (CPFV), published in September 2016, that every community pharmacy across England should be recognised and valued by service commissioners, healthcare professionals, patients and the public as the:

- facilitator of personalised care for people with long-term conditions
- trusted, convenient first port of call for episodic healthcare advice and treatment
- neighbourhood health and wellbeing hub.

To support community pharmacy teams and the roll-out of the vision of the CPFV, the sector also published Making it Happen in January 2017, which set out the immediate core actions for community pharmacy and outlined specific accelerators and pathways to integration. We believe these actions continue to provide a starting point for achieving successful partnerships and achieving new ways of working with other primary care services and beyond. They are to:

- Raise awareness of community pharmacy services with the public, and strengthen relationships with service users
- Support local leaders to build partnerships with colleagues across the health and care system
- Harness technology and secure digital integration
- Empower the workforce to develop their skills, manage change and work effectively within new structures, cultures and systems
- Establish new ways of working and delivering integrated care, supported through appropriate funding and contracting mechanisms
- Proactively support and facilitate sector development, and change management

Community pharmacy will do its part, but to have the fullest impact on patient outcomes and population health, there must also be a funding model, and a legal and regulatory framework, that is enabling, longer-term and future-proof, and above all recognises the contribution community pharmacy does and could make to population health outcomes.

The funding mechanism must take account of the current and potential future increase in more varied service provision. These are likely to go beyond the transactional/item-based dispensing of medicines, towards services that support self-care, assist patients to manage their conditions safely and effectively, and provide advice, sign-posting and appropriate referrals to other parts of the NHS. It must also recognise that, while patients and the public often associate strongly with a main geographic sense of place, they may also have multiple geographic 'centres of reference'. Funding flows into community pharmacy must incentivise a level of consistent service provision England-wide, while embracing a diversity of contractor-led delivery models. Meanwhile, the legal and regulatory framework that surrounds community pharmacy, currently subject to review, must be updated more rapidly to better recognise how pharmacists do and can work. This includes the evolving skills of regulated and non-regulated roles in the pharmacy team, and how technology – including digital and artificial intelligence – is changing the practice environment and has further potential to change it for the better.

Above all, how community pharmacy is funded and governed must be both cost-effective for the NHS and cost-effective for contractors to deliver. Without this, the greatest loss will be to patients and the public through fewer services or the missed opportunity to create those that best meet their health and wellbeing needs.

Consultation questions

1. What are the core values that should underpin a long-term plan for the NHS?

The development of a long-term plan for the NHS, extending over the next ten years, has the potential to provide a vital framework within which all service providers and contractors can recognise, understand and realise their potential, for patients and the public. We want to ensure community pharmacy can play its part in that and has the opportunity to present its vision for the future.

For the NHS at-large, we believe the key themes must include: preventing ill health and promoting wellbeing; committing to more long-term and cost-effective service, funding and workforce planning; making person-centred care a systematic reality; equipping health professionals to support evolving patient needs; creating an 'enabling' contractual environment for providers and contractors; achieving better vertical and horizontal service integration; and developing new cost-effective referral pathways.

Specific to community pharmacy, we would like to see the following enabled and facilitated by the NHS long term plan:

- An enabling and cost-effective funding and legal/regulatory framework.

- Building on current initiatives to achieve fuller digital interoperability between community pharmacy and other services including general practice, such as:
    - allowing pharmacy professionals to have read and write access to a single shared patient record,
    - rolling out electronic Repeat Dispensing nationwide,
    - electronic referrals to/from community pharmacy and other services including better integration with NHS111 and urgent cares systems – e.g. through further roll out of digital 'Pharmacy first' minor illness schemes to support self-care.

- Commissioning a national community pharmacy-led Care Plan Service to better support patients with long-term conditions.

- Creating an enhanced role for community pharmacy building on the Health Living Pharmacy model in conducting health checks or other preventative activity such as smoking cessation services – including population-level strategies in partnership with GPs.

- Enhancing and extending community pharmacy-based medicines optimisation activity, such as medication reviews and discharge medication reviews.

- Expanding the role for pharmacy technicians in managing technical operations in the dispensary, to allow pharmacists to take on a more clinical patient-facing role.

2. What examples of good services or ways of working that are taking place locally should be spread across the country?

In Annex 1, we have set out a range of recent or ongoing initiatives that are examples of local community pharmacy services, from across the UK, we believe could be spread wider throughout England. Some of these have already involved one or more CCA member companies and/or other parts of the community pharmacy sectors.

A notable example of existing good practice in scaling-up initiatives in community pharmacy is the community pharmacy seasonal influenza (flu) vaccination service for at-risk groups. During the 2017-18 flu season, community pharmacists in England administered over 1.3 million vaccinations to patients under the national NHS Flu Vaccination Service, which grew from local pilot activity. This demonstrates the ability and appetite from the sector to grow services at scale that can have a notable impact on population-based healthcare.

A similar approach could be applied to, for example, England-wide coverage of smoking cessation services. These are currently subject to varying local commissioning models and there can be high costs to contractors to adapt to local contacting requirements - despite an argument towards standardisation for patients to avoid perception of post-code lotteries.

3. What do you think are the barriers to improving care and health outcomes for NHS patients?

At present there are a number of system-related barriers preventing more integrated and cost-effective service delivery by community pharmacy. We would like the NHS long term plan to demonstrate a commitment to sweeping away such unnecessary constraints that add no benefit

to the patient experience, the nature of services they receive or patient safety. More often they are no more than products of history, custom and practice, or a lack of co-ordinated planning and foresight.

We think the following barriers must be overcome to help community pharmacy further contribute to improving care and health outcomes for NHS patients:

Complex contracting – The complex array of current commissioning routes risks becoming a barrier to integrating community pharmacy services with other parts of the health and social care system, such as general practice.

Service fragmentation – The patchwork of locally commissioned community pharmacy services means the opportunities to scale-up initiatives, that could have population-wide impact, is laboured and slow. It also results in perceptions of post-code lotteries by patients and the public and lack of awareness of where the mix of services are being delivered.

Poor digital integration – Effective integration between community pharmacy and other parts of the NHS is significantly hindered by a lack of interoperability with digital systems. This includes allowing pharmacists to see, document and share clinical information about patient care by having both read and write access to the clinical records held by other healthcare professionals.

Weak inter-professional relationships – Collaborative working can be impeded by lack of inter-professional understanding and constructive relationships. The more community pharmacy is 'around the table' with other health professionals, service providers and decision-makers, the more easily unnecessary barriers can be overcome.

Under-utilisation of professional staff - To make the most of the skills of pharmacists, pharmacy technicians and the whole pharmacy team, there needs to be a shift in the balance of work that optimises the impact of their training on service provision. For example, pharmacy technicians could undertake more dispensary work and free up pharmacists to spend more time delivering clinical services within the pharmacy.

Section 1: Life stage programmes: staying healthy & ageing well

1.5. What is the top prevention activity that should be prioritised for further support over the next five and ten years?

Community pharmacy already plays a visible role in preventing ill health through its advocacy of self-care, provision of flu vaccination services, stop smoking support, blood pressure checks and more. The Health Living Pharmacy initiative, for example, provides a framework within which pharmacies can further develop as providers of healthy living advice, lifestyle interventions and public health services. There are now over 9,500 Level 1 HLPs across England who promote health, wellbeing and self-care. Through close working with commissioners, there are opportunities to advance these Level 1 HLPs further to Levels 2 and 3, to provide more preventative services and treatments to meet the health and wellbeing needs of local populations.

Nevertheless, we believe there is more that could be achieved by community pharmacy becoming much better integrated with other parts of the health system, being supported by enabling and cost-effective commissioning and funding frameworks, and becoming

surrounded by proportionate regulatory interventions to become the natural home of health promotion and prevention of ill health.

The reach and extent of patient and public contact achieved by community pharmacies, makes them a local, accessible and available source of health information at a variety of times and locations convenient to the patient. According to PSNC, around 1.6 million people visit a pharmacy in England every day. There are 11,616 community pharmacies in England and we represent almost half of these in our CCA membership. Over 1,100 community pharmacies are open 100 hours every week, and over 1,000 CCA member pharmacies are situated in supermarkets or other hybrid retail settings. This makes them not only highly accessible for people with existing health conditions and needs, but for engaging and communicating with people who may not already have diagnosed health conditions.

The key to harnessing the greater potential that community pharmacy provides is growing patient and public, and other health professional, understanding of the role of community pharmacy and the professionals that make up the pharmacy team. This includes how pharmacists and other trained staff are already educated and equipped to promote healthy lifestyles through facilitating access to and understanding of health promotion information; employing the appropriate testing techniques in order to promote health; and identifying inappropriate health behaviours and recommending suitable interventions (as set out in the General Pharmaceutical Council's Standards for the Initial Training and Education of Pharmacists). Particular areas of untapped potential in this regard include frailty and falls prevention initiatives and sign-posting to NHS or voluntary sector mental health services, for example.

1.6. What are the main actions that the NHS and other bodies could take to:

a) Reduce the burden of preventable disease in England?
b) Reduce preventable deaths?
c) Improve healthy life expectancy?
d) Put prevention at the heart of the National Health Service?

Community pharmacies are a source of healthy living advice and an important contributor to supporting the prevention of ill health. They also provide services that can alleviate pressures on other parts of the health system, including general practice and urgent care services, and make a significant contribution to improving public health and wellbeing through delivering locally commissioned public health services, providing social support and contact, and their wider role as employers and responsible businesses.

The Healthy Living Pharmacy model is already well-embedded, with over 9,500 community pharmacies accredited to provide expert proactive support for healthy living. In Annex 1 we provide case study examples of prevention services that community pharmacies have been implementing to improve healthy life expectancy, including a Type II Diabetes Prevention service focused on diet and lifestyle change. We also detail the Community Pharmacy Future project pathways for pharmacy services, designed to provide patients and carers with practical support to achieve the best outcomes from medicines that have been prescribed for long-term conditions, and to reduce the burden of preventable disease in England.

However, there is significant potential to expand and enhance this contribution to enable all community pharmacies to operate as neighbourhood health and wellbeing centres, providing the 'go-to' location for support, advice and resources for staying well.

If prevention is truly to be at the heart of the NHS, the following must be better embedded England-wide:

Public Health Campaigns – Public health information and communication must be more coordinated nationally and locally, better funded and more targeted and impactful. This could be through the development of fewer but higher quality person-centred campaigns; more evaluation and learning; and more varied use of community and public engagement techniques. Community pharmacies proliferate with opportunities and calls to run short-term and short-notice campaigns, which can often result in either non-participation or a complex and confusing mix of health messages for patients and the public. As large, nation-wide, pharmacy companies, CCA members have the benefit of operating at scale and with expertise in marketing communications. We would welcome the opportunity to further harness this for the benefit of patients by working with local and national bodies, including NHS England and Public Health England, to craft and deliver impactful campaigns.

Referrals from and into community pharmacy – To reduce the burden on general practice, community pharmacists and their teams should be able to refer and book people directly into other primary, community or secondary care services as part of agreed pathways. This includes fast-tracking them where necessary and enabling pharmacists to refer directly to specialist services where appropriate. This would help ensure patients have quicker access to the service that best meets their needs, rather than having to unnecessarily make GP appointments to get referrals.

Social prescribing support – NHS leaders and local authorities should explore digital and in-person opportunities to enable community pharmacy teams to refer people to community organisations that support health, wellbeing and independence. These include local community groups, leisure and library facilities, social care, housing and welfare services. Some pharmacies could also host outreach or drop-in facilities for these partner organisations. Community pharmacy team members are already routinely involved in the community-based health and wellbeing activities that they organise.

Mental health support – People already receive help in maintaining their mental, as well as physical, health and wellbeing from community pharmacy teams but this could become more widespread. For people experiencing, or being at risk of, mental health problems their community pharmacy team can operate as part of their extended community support network that is observant and responsive to any changes in mood or behaviour, and offering signposting and referral to further support if required.

1.8. Are there examples of innovative/excellent practice that you think could be scaled up nationally to improve outcomes, experience or mortality?

In Annex 1 we set out many examples of local services or projects that could be scaled-up and rolled out nationally across community pharmacy in England. These include:

Pharmacy Care Plan Service – this focuses on supporting patients over 50 years old who are prescribed multiple medicines, including for diabetes or cardiovascular disease, to achieve health goals through a personalised care plan.

Discharge Medicines Review Services, Wales – community pharmacies receive electronic secondary care discharge letters as a trigger for potential Discharge Medicines Reviews.

Dermatology services, Staffs, Shropshire, IoW – following training, community pharmacists supply medicine under a Patient Group Direction for people presenting in the pharmacy with minor skin conditions.

1.9. How can personalised approaches such as paying attention to patient activation, health literacy and offering a personal health budget reduce health inequalities?

According to Public Health England's latest Health Profile for England 2018 report, in the richest areas people enjoy 19 more years in good health than those in the poorest areas. The Post Implementation Review of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, found that in the most deprived areas there are 2-3 times as many pharmacies. Therefore, community pharmacy teams have the potential to play a critical role in improving the health of deprived communities by offering convenient and equitable access to wellbeing and health improvement services. Pharmacy team members are accessible to individuals who may not access conventional NHS services, which can help to improve health inequalities. They are also well-placed to use the Patient Activation Measure (PAM) and motivational interviewing to improve patient activation and self-management of conditions, such as Type II Diabetes.

1.11. What more could be done to encourage and enable patients with long-term health issues to play a fuller role in managing their health?

Almost all pharmacies in England have a private consultation area making it possible to deliver a range of medicines optimisation-related services. This includes Medicine Use Reviews (MURs) and New Medicine Service (NMS) interventions, designed to help people use their medicines as intended, improve adherence and reduce waste. However, we believe these services should be even more integral to supporting and empowering people with long-term conditions to manage their own health. There is scope, for example, to further enhance and expand the services pharmacy teams currently provide including helping people obtain medicines safely and efficiently and use them as effectively as possible.

According to the December 2016 Community Pharmacy Clinical Services Review the MUR service could be further developed to include on-going monitoring and regular patient follow up. A re-developed service should also be able to take advantage of referral schemes and widespread electronic repeat dispensing (eRD) within community pharmacy to support transfers of care and to target patients at high risk or those with multiple co-morbidities, as well as those with single conditions such as diabetes, hypertension and COPD.
To achieve an enhanced role for community pharmacy in supporting people with long-term conditions, community pharmacy teams and other health professionals will need to work in partnership across the health and care system, including in the context of the new care models that are emerging across the country. This enhanced role for teams in supporting people with long-term conditions should be based around the principles of medicines optimisation and personalised care and support planning, and build on the clinical knowledge and procurement skills of community pharmacists to promote evidence-based and cost effective use of medicines. For this role to be as safe and effective as possible, community pharmacy professionals should also have read and write access to shared patient care records.

In Annex 1 we include examples of a Pharmacy Care Plan service and a self-management programme designed to empower patients to take a fuller role in managing their health.

1.12. How can we build proactive, multi-disciplinary teams to support people with complex needs to keep well and to prevent progression from moderate to severe frailty for older people?

Community pharmacy sits at the interface between local communities and health and care services. It is an essential component of primary care and urgent care infrastructure and has a valuable role in supporting older people, through medicines optimisation initiatives like Medicines Use Reviews (MURs) or supporting hospital discharge. Services such as these and others could be further developed within pharmacy premises, or virtually and remotely, if the legislation surrounding community pharmacy was more flexible. They can also contribute to reducing future avoidable hospital admissions, for example:

Reducing admissions – Older patients on four or more medicines are at greater risk of having a fall. Regular medication reviews, such as MURs or the New Medicine Service, play an important part in falls prevention, including identifying those at risk of falls or setting up fracture prevention services for older people. These have each been found to reduce hospital admissions and the potential need for admission to a care home.

Supporting discharge – A key challenge for patients, older people, carers and healthcare professionals associated with admission to and discharge from various health care settings is the lack of timely, relevant and sufficient information regarding medicines and especially changes to medicines. A more integrated service across boundaries and between health professionals, including community pharmacy, could reduce the risks associated with transfers of care.

In Annex 1 we set out a number of case study examples of community pharmacy supporting people with complex needs or supporting and preventing frailty:

Four or More Medicines Service, Wigan – A pharmacist-led prescribing review support service, for 65-year olds relating to medicines adherence, pain, falls risk and general health.

Primary Care Cluster Polypharmacy Service, Bedfordshire - A pilot medicines checking service for over 75-year olds on 10 or more medicines, resulting in reduced GP appointments.

Community Pharmacy Domiciliary Service, Cornwall – A community pharmacy home visiting service supporting patients to manage their medicines at home through action planning with the patient, that reduced unplanned hospital admissions.

There are also various ways community pharmacy and other primary care and wider health and social care services could work more closely to build proactive multi-disciplinary teams and services. These could include:

Multi-disciplinary education and training – Both initial and specialist education and training, and continuing professional development, and joint competency frameworks such as the joint Competency Framework for all Prescribers published by the Royal Pharmaceutical Society.

Multi-way patient referrals – Including into and out of community pharmacy into general practice, community services and secondary care.

Single patient records – Providing multi-professional read and write access, including by the community pharmacy team.

Wider multi-professional understanding – Including of the skills and knowledge of community pharmacists, and clearer clinical decision-making rights within their existing

scope of practice. The Walk in my Shoes initiative helps to encourage mutual understanding between the roles of community pharmacy and general practice.

Section 2: Clinical priorities

2.4. What actions could be taken to further reduce the incidence of cardiovascular and respiratory disease?

Community pharmacies can support the prevention of cardiovascular and respiratory disease through provision of, for example, walk-in services for the detection of pre-high or high blood pressure and through healthy living advice and support to help prevent hypertension in at-risk groups. Improving the commissioning of face-to-face blood pressure measurement services, and an increase in the prevalence of high-quality blood pressure monitors located within pharmacies, would enable community pharmacy to fulfil its potential contribution to reducing incidence of cardiovascular or respiratory disease over time.

In Annex 1 we describe several case studies on respiratory and cardiovascular disease prevention and support services, including:

Chronic Obstructive Pulmonary Disease case finding, The Wirral – Identification of patient risk factors and condition management, to avoid escalation and unnecessary costs.

Atrial fibrillation screening in pharmacies, London – Pharmacy-based blood pressure and targeted atrial fibrillation checks.

Blood pressure drop-in, Wakefield – A partnership approach to establishing the value of opportunistic testing from a range of community locations, including community pharmacies.

2.5. What actions should the NHS take as a priority over the next five to ten years to improve outcomes for those with cardiovascular or respiratory disease?

We strongly advocate the further development and wider roll-out of a Community Pharmacy Care Plan Service to improve outcomes for patients diagnosed with cardiovascular or respiratory disease.

According to the British Lung Foundation, there are an estimated 1.2 million people in the UK with diagnosed Chronic Obstructive Pulmonary Disease (COPD), and it the most common respiratory cause of emergency admission to hospital. We believe there is more that can be done by community pharmacy in the detection and management of COPD and related conditions, where the funding can be appropriately targeted.

Also, as NHS England reported in the spring, between February and November 2017 more than 12,500 asthma patients at high risk of suffering a severe asthma attack have been identified and referred for a full asthma review from community pharmacy. This shows the impact the sector can have on early detection of respiratory conditions such as asthma, as supported by the Quality Payments in Pharmacy Scheme.

In Annex 1, we set out case studies on the Pharmacy Care Plan Service, the EPIC Project in West Yorkshire providing COPD condition management support, the COPD Support Service on the Wirral, and the Community Pharmacy Asthma Service in Leicester.

Section 3: Enablers of improvement

3.1. What is the size and shape of the workforce that we need over the next ten years to help deliver the improvements in services that we would like to see?

The NHS is moving towards more multi-disciplinary working and further embedding integrated care pathways that traverse primary and secondary care, health and social care services and providers/contractors. It is vital Health Education England (HEE) works collaboratively with all parts of the health system and others, such as the Centre for Workforce Intelligence (CfWI), to ensure there is robust longitudinal workforce planning, and that the training, development of health professionals is timely and future proof. This is to effectively support the delivery of services that patients need, into the medium and long-term. Workforce planning must be based on independent evidence and effective modelling, while realising the full potential of health professionals, such as community pharmacy teams, must not be unnecessarily constrained by out-of-date and burdensome legislation and regulation.

We want to see community pharmacy as an integral part of this planning, to ensure the skills, knowledge and human resource potential available within the whole community pharmacy team is fully harnessed. This includes making sure teams remain resilient, empowered and motivated to deliver existing services in a time of economic and financial uncertainty and change. It also includes further developing the team, so it becomes equipped to deliver new services in the future.

At present we are seeing increasing attrition rates in community pharmacy, especially for non-regulated pharmacy staff and many pharmacists are choosing to embark on portfolio careers working across different healthcare settings. We encourage HEE, together with NHS England, to consider how to address these issues in the pharmacy workforce, in collaboration with pharmacy employers. Over five years ago, the CfWI carried out a strategic review of the future pharmacy workforce to inform pharmacist student intakes. We would like to see an update of this important work, to ensure any forecasting and planning is accurate, especially as so many new opportunities for pharmacists have been well-established in the last few years (e.g. in GP practices, care homes and urgent care settings).

We also observe, for example, the recent initiative to recruit 'clinical pharmacists' into general practice, which we believe includes attracting pharmacy professionals from community pharmacy. There is a risk that without adequate planning this could result in short to medium term imbalances in workforce supply in some parts of the sector. There could also be unintended consequences resulting from heightened awareness and funding of one part of pharmacy over others, that results in a rapid over segmentation of the sector. We welcome new opportunities for all pharmacists, but the adequate pipeline of skilled pharmacy professionals in all practice settings needs to be ensured to meet the evolving needs of patients. Overall, pharmacy needs to remain an attractive profession for those already practising within it - in career development and remuneration terms, and for prospective new pharmacy professionals.

Further to the current situation, the world of pharmacy is moving at pace and we are seeing changes in technology, significant advances in medicines development, and shifts in consumer demand and patient behaviour across the UK. In particular, we foresee the pace and volume of change only accelerating as we move further into the modern digital and genomic era of medicines and healthcare. We are aware that the NHS has ambition for pharmacists and the pharmacy sector to step up into more clinical roles in a variety of settings and integrated care models. In this light, we do not want to see opportunities for community pharmacy to make this contribution to be missed because planning and decision-making is not joined up, or is not

informed by the realities, experience and knowledge-base of community pharmacy contractors.

We also want to ensure the legal and regulatory framework surrounding community pharmacy remains fit for purpose. We have reflected in our recent response to the Department of Health and Social Care consultation on rebalancing pharmacy legislation and regulation that we want pharmacy regulation to be an 'enabling' force that avoids perpetuating unnecessary constraints, that impede the appropriate and necessary development of regulated pharmacy professionals and services. We think the time is now right to re-consider the responsibilities and activities of regulated and non-regulated pharmacy roles, including the Superintendent Pharmacist, Responsible Pharmacist, pharmacy technicians and others, to support the development of a pharmacy team that is fit for the future.

3.2. How should we support staff to deliver the changes and ensure the NHS can attract and retain the staff we need?

Good health and social care relies upon easy access to trusted, competent and safe professionals, who engage with patients and the public with respect and compassion. Community pharmacy teams, often located at the heart of the community, have the knowledge, capacity and skills to be a first port of call for many patients and carers and already fulfil this role. As we comment elsewhere in our response, we want to see community pharmacists and pharmacy technicians working to their full scope of practice. It is disempowering and demotivating for pharmacy professionals to be constrained in their practice not because they do not have the training, but because the services they are already trained to provide are not adequately funded or consistently provided across the system. It is also a missed opportunity for patients and the public because it means they potentially don't have access to services that otherwise could be provided locally to them, and it is an opportunity cost to the NHS overall.

We strongly welcome ongoing and system-wide training and development of the pharmacy team. Arising from the already valuable services being delivered, training and development must take place in a way that does not disrupt current service provision and incentivises participation. Local variation in training provision, lack of backfill cover and short notice of an opportunity can create significant challenges for busy community pharmacies. It also works against the intended benefits of training because it has not been designed with the pharmacy professional in mind. Although regionally-led delivery of training and development works in some instances, we would like to see more funding being made available to pharmacy contractors, giving them more flexibility on where they would like to obtain training from, and how/when they would like it delivered. We would also like to encourage Health Education England to take advantage of the dedicated training providers, in-house training departments, expertise and e-learning platforms already available and working well across the community pharmacy sector.

An example of an alternative training model is NHS Education for Scotland's model of allocating funding to pharmacy contractors for training and development, so that individual employers can identify local or national training priorities. They are then enabled to deliver the training most appropriate for their teams, in the most appropriate way, using a timeline that works for them. We would like to see developments such as this be a visible part of HEE's national workforce strategy, which we expect to be published soon. That strategy must set the ambition for future workforce investment across the entire NHS, including community pharmacy.

3.4. How can the NHS help and support patients to stay healthy and manage their own minor, short-term illnesses and long-term health conditions?

The role of community pharmacy in supporting self-care, including to relieve pressure on GP services could be even further enhanced if community pharmacists and their teams were able to refer and book people directly into other community or secondary care services, fast-tracking them if necessary. Enabling pharmacists to refer directly to specialist services where appropriate could help ensure patients have quicker access to the service that can best meet their needs, rather than having to unnecessarily make GP appointments to get a referral. According to the Proprietary Association of Great Britain (PAGB)'s interim White Paper on a long-term vision for self-care, an estimated £810m is spent every year on GP appointments for self-treatable conditions.

A community pharmacy is one of the most accessible places patients and the public can receive accurate, timely and safe advice and treatment for minor ailments, injuries and self-limiting conditions. To facilitate and embed the use of 'pharmacy first' for non-emergency episodic care into the behaviours of patients and the public there must be more public awareness of what pharmacies can provide and what services are available where. Building on this there should be systems for seamless triage within community pharmacy and referral on through local urgent care pathways.

Empowering individuals with the information and confidence to self-care, manage their own health and wellbeing, or seeking professional help when necessary, ultimately gives them greater control over their own health and wellbeing and can encourage healthy behaviours. We believe the NHS and Public Health England should continue to invest in and expand their joint Stay Well Pharmacy campaign to improve health literacy and public understanding.

In the case study examples we set out in Annex 1, we describe the 'Test and Treat' sore throat service soon to be delivered in Wales, as an example of encouraging self-care and reducing winter pressures on GP services.

3.5. How could services like general practice and pharmacy, work with other services like hospital services to better identify and meet the urgent and long-term needs of patients?

Allowing community pharmacy professionals to have read and write access to shared full patient care records (with patient consent), would allow for a more seamless transition between care settings and a fuller picture of a patient's health needs to support their overall care by different members of multidisciplinary teams. Similarly, regular correspondence between pharmacy and general practice teams should take more advantage of secure digital communication, such as through NHS Mail in community pharmacies. Local community pharmacists should also be more involved, alongside other local professionals and patients, in practice meetings, to contribute to local population-level planning and decision making.

Inward and outward referral services from community pharmacy would also improve the patient experience allowing for more seamless transitions between providers, for instance in referrals from community pharmacy-based screening/case finding/phlebotomy services into secondary care specialists; from NHS111 or urgent care services to community pharmacy for treatment and advice to support people with self-care; and from hospital services to nominated community pharmacies to encourage a community pharmacist-led medicines reconciliation and Discharge Medication Review.

We set out the following examples in the case studies in Annex 1:

Refer-to-Pharmacy, East Lancashire – An initiative enabling hospital pharmacists to directly refer patients from hospital to their community pharmacy, for various post-hospital support with their medications.

Hospital discharge and medicines reconciliation, North East England – Details of patient medicines were electronically transmitted to a nominated community pharmacy on discharge from hospital.

*Electronic transfer of care to community pharmacy, Cheshire and Wirral – P*atients with poor mental health are referred from mental health trusts to their community pharmacy for additional support with medicines

3.6. What other kinds of professionals could play a role in primary care, what services might they be able to deliver which are currently delivered elsewhere and how might they be supported to do so?

We believe the health system should be optimising the resource that community pharmacists and pharmacy technicians provide by enabling services that allow them to practise to their full scope of practice. For example, pharmacists should be empowered to use their clinical and professional expertise to provide the very best patient-centred care that they are trained to deliver. To enable this, we believe the scope of practice of different registrants needs to be more clearly defined, to allow for a series of activities to be defined which a pharmacy technician can be responsible for both in general and in the temporary absence of a pharmacist, where they have the skills to do so.

There are also opportunities for members of the primary care team, including non-regulated pharmacy staff, to work more closely with other professionals, such as dietitians, in running community-based weight management services or for pharmacists and practice nurses to jointly run diabetes outreach clinics, for example.

3.7. How could prevention and pro-active strategies of population health management be built more strongly into primary care?

We have described elsewhere in our response that we think a new funding mechanism for community pharmacy would better enable, incentivise and resource new services development that supports wellness and ill health prevention and condition management. The NHS funding that is available to community pharmacy has historically been dominated by fees per item dispensed. We would like to see a more mixed funding model emerge, to include aspects of capita and outcomes-based payment to really embed population health management into community pharmacy as a core contributor of primary care services. New forms of contracting and fees could help ensure that all relevant providers are working together to deliver the best and safest care for the local community, in the most cost-effective way.

We acknowledge the opportunity the draft Integrated Care Provider Contract may provide in doing this, arising from outcomes-based models of payment, but the contractual framework for sub-contractors under a Lead Provider must be workable for all potential contractors. Alongside this we believe there is opportunity for greater collaboration between general practice and community pharmacy to jointly develop and deliver outcomes-based population-level prevention strategies, such as around flu vaccinations.

We include examples of effective multi-disciplinary working to improve population health and reduce preventable disease in Annex 1:

Flu vaccinations, Devon – GP practice group and community pharmacies work together to take advantage of all opportunities to promote flu vaccines and recommend the easiest, most appropriate setting for individual patients.

Minor Eye Conditions, Stockport – Prescribing and dispensing service involving local optometrists and community pharmacists set up for the treatment of minor eye conditions.

3.8. How can digital technology help the NHS to:

a) Improve patient care and experience?
b) Enable people and patients to manage their own health and care?
c) Improve the efficiency of delivering care?

Community pharmacies are already exploring and implementing digital technologies designed to improve the care delivered to their patients, including through automating elements of the dispensing process, introducing digital alert notifications for patients collecting their medicines and interacting with patients through digital media.

However, improved digital interoperability would enable significantly improved patient care, experience and efficiency of service provision. There are several means by which community pharmacy could benefit from greater interoperability between existing NHS IT systems and the use and development of digital technology, as part of a health system-wide digital strategy. For example, permitting community pharmacy professionals to have read and write access to shared full patient care records (with patient consent). This would allow for a more seamless transition between care settings and a fuller picture of a patient's health needs to support their overall care by different members of multidisciplinary teams. It would also improve patient outcomes and reduce the risk of re-admission, such as due to errors caused by information breakdown.

The consequences of a lack of interoperability between digital systems in pharmacy in England were summed up two years ago in the Community Pharmacy Clinical Services Review:

"The poor availability of the information … is a critical barrier. To unlock the full potential of community pharmacy requires a step change in the availability of information to inform clinical decision making. To overcome it will require greater digital maturity and interconnectivity to allow pharmacy staff to see, document and share clinical information about patient care with the clinical records held by other healthcare professionals…This is a fundamental requirement if new services are to be safe and effective so that the whole multidisciplinary team, with responsibility for direct care of an individual patient, can see and understand the rationale for actions taken and recommendations made by pharmacy staff."

Yet, as we set out in our case study examples in Annex 1, progress is being made in Wales towards interoperability between primary and secondary care and community pharmacy, through the 'Choose Pharmacy' platform that aims to improve digital interoperability.

We also think artificial intelligence and the development of automation in the dispensary, to support dispensary operations, could release staff capacity and allow community pharmacy teams to deliver more patient-facing services, such as delivering clinical medication reviews. Similarly, in order to improve the efficiency of delivering care, electronic Repeat Dispensing (eRD) should be fully optimised and rolled out nationally for all patients who are stable on their medicines. Incentivising the use of eRD for both community pharmacies and GPs would help ensure national uptake and reduce variation in repeat prescription services, making it clearer for patients how to access their medicines.

Annex 1: Local Community Pharmacy Case Studies

We have compiled a selection of thematic case studies taken from a range of sources (see below), representing England, Scotland and Wales, which we have also referred to in summary in our main response. CCA member companies have been involved in some of this activity and some examples have been taken from the wider pharmacy sector. We can provide signposting to more information on request. We have referenced the relevant discussion document question by case study theme, although each also has more widespread relevance.

Many of the case studies below also have the potential to be scaled-up England-wide.

Reducing preventable disease *(Question 1.6 and 3.7)*

Type II Diabetes Prevention Scheme

According to Public Health England, the number of people with diabetes is expected to increase by a million – from just under 4 million people in 2017 to almost 5 million in 2035. As part of the NHS Diabetes Prevention Programme (NHS DPP) started by NHS England in 2016, LloydsPharmacy has carried out over 10,000 tests to encourage people to change their diet and lifestyle to prevent a future diagnosis of diabetes.

Early Lung Cancer Detection Referrals, Doncaster / London

Lung cancer is one of the biggest causes of cancer death in Doncaster, making early detection a key local health priority. A CCG-led 12-month community pharmacy referrals pilot[1] began in September 2015 involving nine community pharmacies, covering around 70,000 local people. Following training, community pharmacists were able to directly refer patients to hospital for a chest x-ray. The scheme aimed to increase the early detection of lung cancer, reduce the number of patients presenting at A&E with advanced lung cancer, and increase the diagnosis of lung abnormalities such as COPD. 16 patients were offered a chest x-ray following consultation in the pharmacy. No patients were diagnosed with lung cancer, but one stable lung condition was confirmed. A similar pilot[2] in south London was carried out for 12 weeks where 55 out of 60 referrals for a chest x-ray were considered appropriate. 30% of patients attending their clinic appointment were found to have undiagnosed chronic obstructive pulmonary disease (COPD).

Primary care collaboration to improve flu vaccine uptake, Devon

In 2016, Beacon Medical Group Primary Care Home[3] worked with local community pharmacists to help improve local flu vaccination rates. Rather than competing for patients, surgeries and community pharmacies worked together to recommend a vaccination setting that was most appropriate for individual patients. Vaccination uptake in those with respiratory conditions increased from 39% to 52%, for carers it rose from 26% to 33%, and in the 16 to 65-year-old age group, vaccination rates increased from 37% to 47%. The project fostered closer working relationships between GPs and community pharmacists, with a more coordinated campaign to drive a community movement around flu prevention and better outcomes for patients.

Community Pharmacy and Minor Eye Conditions, Stockport

The Minor Eye Conditions Service (MECS)[4] in Greater Manchester provides diagnosis and treatment for patients with minor eye conditions. It aims to direct people to the right care, to reduce pressures on GP practices and to prevent unnecessary A&E appointments. Pharmacists, alongside other primary care professionals, are able to triage and refer patients directly to an optometrist who is part of the service who will then offer the patient an acute examination within 48 hours of the request. Patients could have a prescription issued to them through the MECS and take this directly to their community pharmacy for dispensing. The pharmacy and optometry teams involved also set up joint learning projects (similar to the 'walk in my shoes' initiative) to collaborate further and to learn more about the services that they each provide to Stockport residents.

Improving health outcomes *(Question 1.8)*

Pharmacy Care Plan Service, North Kirklees and Wakefield

In 2015, the Community Pharmacy Future project, created by Boots UK, LloydsPharmacy, Rowlands Pharmacy and Well, trialled the Pharmacy Care Plan (PCP)[5] service to support the setting and achieving health goals with patients aged over 50 years old, who were prescribed multiple medicines (including at least one for cardiovascular disease or diabetes). Eligible patients were identified and had a one-to-one discussion with a community pharmacist to establish a personalised PCP. The PCP was used in six-month and twelve-month reviews to monitor progress towards health goals and agree new goals where appropriate. The service was provided in 52 community pharmacies in North Kirklees and Wakefield. The evaluation found significant improvements in patient activation score, blood pressure, medicines adherence and quality of life of those enrolled in the service. HDL cholesterol was reduced significantly and QRisk2 scores increased significantly over the course of the 12 months. Overall, participation in the PCP service was generally associated with improvement in key clinical metrics over 12 months and the service would be cost-effective to roll-out.

Discharge Medicines Review, Wales

The 'Choose Pharmacy' platform in Wales allows community pharmacies to have access to electronic discharge advice letters (e-DAL), sent directly from secondary care settings to a patient's designated community pharmacy to consider the patient for a potential Discharge Medicines Review (DMR) service. The community pharmacist completes part 1 of the DMR on the electronic system which is populated directly from the eDAL. The GP practice can then be alerted to any discrepancies with prescription issued. NHS Wales commissioned an independent evaluation[6] of the DMR service and found 39% of the interventions made by community pharmacists providing the service had the potential to prevent people needing to go to A&E departments. It concluded that the service is very cost effective, with a suggested three to one return on investment, mainly attributed to reductions in hospital admissions, visits to A&E departments and medicine waste. The evidence informed the Welsh Government's continued funding of this service as part of the contractual framework for community pharmacy in Wales.

Self-management support programme, Newham

The Self-management Support Programme[7], developed by Newham CCG, targets patients with two or more long-term conditions. Eligible patients work with their pharmacist to develop a personalised 'wellbeing plan'. Over the course of 12 weeks, the patient has three one-to-one

sessions with the pharmacist to discuss their progress. The community pharmacist can also help connect patients to local services and community groups. The development of the patient-specific plan helps individuals to be more in control of their own wellbeing which is especially important for patients living with a long-term condition.

Dermatology services, Staffordshire, Stoke on Trent, Shropshire, Isle of Wight
In several regions[8], community pharmacists who have taken part in relevant training can supply medication using a Patient Group Direction for people who present with minor impetigo on one area of the body. Community pharmacists are able to spot red flags and refer the patient to their GP if there are, for example, multiple site infections or the patient advises they have had a previous impetigo infection in the last three months. In some areas, similar models exist for uncomplicated urinary tract infections or other minor conditions.

Keeping well and preventing frailty *(Question 1.12)*

Four or More Medicines Support Service, Wigan
A pilot co-ordinated as part of the Community Pharmacy Future project in 2015 across 25 pharmacies saw 620 patients recruited to a community pharmacist-led support service for those aged over 65 with at least one long-term condition. Patients had consultations relating to medicines adherence, pain, falls risk and general health. Prescribing was reviewed with relation to STOPP-START criteria and consultations continued every two months for six months. The service had an independent evaluation[9] which found improvements in reduced number of falls, increased medicines adherence and improved quality of life.

Primary Care Cluster Polypharmacy Service, Bedfordshire
Polypharmacy can lead to an increase in hospital admissions and falls. Luton Primary Care Cluster has worked with community pharmacists to support polypharmacy (concurrent administration of multiple medicines) in the older population. A three-month pilot targeted people over 75 years old, taking 10 or more medicines. During the pilot, a community pharmacist visited surgeries and housebound patients to explain and check medicines in one-hour consultations. By the community pharmacist reviewing whether they were taking their medicines correctly, and assessing their risk of developing an adverse drug reaction or admission to hospital, initial analysis[10] suggests there was a significant reduction in the number of GP appointments required by the patient group in the subsequent six months.

Community Pharmacy Domiciliary Service, Cornwall
Cornwall has a large population of frail, older people who are taking multiple medicines. To better support and optimise medicines for these patients, Cornwall and Isles of Scilly Local Pharmaceutical Committee worked with Kernow CCG to develop the community pharmacy home visiting service in 2014. This service aimed to help patients manage their medication in their own home, to reduce unnecessary GP and hospital visits. Community pharmacists visited patients to discuss their condition and offer advice around the management of their medicines. An action plan was devised which was shared with the patient's GP and other members of the healthcare team. Patients who participated felt more confident about their medicines and the evaluation found that more than 30% were likely to have avoided an unplanned hospital admission. The scheme also led to reduced prescribing costs and a reduction in the numbers of medicines that would have been wasted.

Reducing cardiovascular and respiratory disease *(Question 2.4)*

Chronic Obstructive Pulmonary Disease (COPD) case finding, the Wirral

This initiative, implemented as part of the Community Pharmacy Future project, sought to identify risk factors attributed to the development of COPD and potentially undiagnosed sufferers. Patients were identified as being at potential risk of developing COPD by trained members of the community pharmacy team looking for common risk indicators e.g. frequent cough medicines requests, requests for smoking cessation consultation/advice, antibiotic and inhaler/steroid prescriptions indicative of regular chest infection. In total, 238 patients took part in 21 community pharmacies in the Wirral. Of those screened, 135 (57%) were at risk of COPD, 88 of whom were current smokers. The evaluation[11] of the project found possible net cost savings of £93,000+ with a total lifetime gain of nearly 20 quality-adjusted life years (QALYs). Cost-saving per patient was estimated to be around £400.

Atrial fibrillation screening, London

A pilot launched across 16 community pharmacies in North London as part of NHS England's 'test-beds programme' in 2016 led to nearly 700 patients being screened for atrial fibrillation. Patients aged 65 and over were targeted for screening and those who produced abnormal results were directly referred to Whipps Cross University Hospital for further diagnostic tests. In the first phase of the pilot, 7% of the approximately 700 patients screened were identified as having atrial fibrillation. If this scheme was carried out across England, an estimated 1,600-1,700 strokes would be prevented per year.

Blood pressure drop-in pilot, Wakefield

According to Public Health England, around 60% of individuals with high blood pressure are either undiagnosed, or not managing their condition to the levels recommended. For five weeks in March and April 2014, a pilot co-ordinated by PHE, Wakefield Council, primary care providers and Community Pharmacy West Yorkshire explored the value of opportunistic blood pressure testing from a range of community locations. In total, 3,632 people were tested during the pilot, 2,019 of them in one of the 49 pharmacies involved. Of those tested, 75% were given healthy living advice about prevention or management of high blood pressure and 67% went on to find out more about their health. 20% of people tested were suspected of having high blood pressure and were referred to their GP, over 500 of whom went on to attend their local practice.

Improving cardiovascular and respiratory outcomes *(Question 2.5)*

EPIC project, West Yorkshire

The EPIC project (Enabling Patient health Improvements through COPD medicines optimisation)[12] was commissioned by Leeds West CCG in 2015. It aimed to improve patients' ability to manage their condition by enhancing their understanding of COPD. High-risk COPD patients at 14 practices in Pudsey, Armley and Bramley were targeted, over a period of four months. This area was chosen as COPD patients there had high rates of hospital admissions and A&E attendance. Each patient had two consultations, eight weeks apart, with a specially trained community pharmacist or pharmacy technician. Over four months, 190 COPD patients were seen by community pharmacists. 95% of patients felt they had a better understanding of COPD following the consultation. Initially pharmacists found that 26% of inhaler devices were not being used properly, dropping to only 3% after patients had taken part.

COPD support service, the Wirral

This service, implemented as part of the Community Pharmacy Future project, aimed to support patients with diagnosed COPD to get the most from their medicines through improved understanding, adherence and technique. 306 patients were recruited by 34 community pharmacies across the Wirral. The initiative resulted in a significant increase in medicines adherence, reductions in overall NHS resource use by patients and significant increase in patients' quality of life. Based on evaluation[13], it is estimated that if the service was rolled out across pharmacies in England to 749,000 patients, the NHS could see annual benefits of: £125.8m savings from unnecessary services; £9m savings resulting from an additional 180,000 people with COPD receiving flu vaccinations; £86.3m disease-related cost savings from supporting people to stop smoking (*lifetime value*) equivalent to 15,000 QALYs.

Community pharmacy asthma service, Leicester

In Leicester, community pharmacy teams were commissioned to support patients in controlling their asthma through delivering asthma reviews which included signposting, medication review and inhaler technique assessments. In total 125 patients were seen as part of the initiative, with 42% saying they had not received a review in their GP practice in the past year and only 15% having an asthma action plan. Outcomes included clinically important improvements in asthma control (as measured by the ACT) in 40% of patients; patient quality of life and inhaler technique. The number of visits to GPs and hospital admissions for asthma-related issues were shown to decrease over the study period.

Staying healthy and self-care *(Question 3.4)*

Sore throat 'Test and Treat' service, Wales

In autumn 2018, up to 70 community pharmacies in Wales will pilot an on-the-spot sore throat swab service, designed to ease pressure on GP practices and help tackle antibiotic resistance. The scheme is part of the 'Choose Pharmacy' suite of services, an extension of the Common Ailments Service in Wales encouraging patients to visit their community pharmacy instead of their GP for minor ailments. Following a clinical examination by a pharmacist, the throat swab will be conducted if appropriate. The test will determine whether the illness is caused by a virus, in which case, no medicines are required. If a bacterial infection is detected, the patient can be prescribed antibiotics by the pharmacists, reducing need for a GP appointment.

Working with others to meet urgent and long-term needs *(Question 3.5)*

Refer-to-Pharmacy, East Lancashire

East Lancashire Hospitals NHS Trust created Refer-to-Pharmacy as an electronic referral system, allowing hospital pharmacists to directly refer patients from hospital to their community pharmacy for various post-hospital discharge support with their medication. Community pharmacists were automatically notified about the discharge and able to access the patient's clinical details. Readmission rates at the Royal Blackburn Hospital reduced from 4.2% to 3.2% between January and June 2016, compared to the same period in the previous year. This accounted for 80 fewer patients being readmitted to hospital wards.

Hospital discharge and medicines reconciliation, North East England
In 2014-15, an electronic referral system was trialled involving two hospitals, 207 community pharmacies and 2,029 patients in the North East of England. As part of the trial, information related to a patient's medicines was electronically transmitted to a nominated community pharmacy on their discharge from hospital. Community pharmacists then provided a follow-up consultation tailored to individual patient needs. Annual savings for 10 of the highest risk patients discharged each day, who were referred for medicines' reconciliation to community pharmacy, was £1.36m[14].

Electronic Transfer of Care to Community Pharmacy (ETCP), Cheshire
The Cheshire and Wirral Partnership pathway refers patients with poor mental health to their community pharmacy for additional support with medicines. The pathway recognises that patients who are discharged from Mental Health Trusts have had intensive care with stabilising mental health and mental health medicines, but that physical health problems also contribute to the data that says patients with mental health problems are at risk of dying on average 15 to 20 years before the general population. The electronic referrals provide community pharmacists with the information they need to provide additional support through MURs to aid inhaler use, diabetes medication etc. The Trust also supply information about medication such as Clozapine supplied in secondary care to ensure that a full record is maintained for the purposes of checking interactions and advising on self-care. Between November 2017 and September 2018, 82 patients were identified and referred for community pharmacy support, with 95% of all referrals completed, implemented or referred on.

Digital technology *(Question 3.8)*

Improving digital interoperability, Wales
The Choose Pharmacy platform has been implemented in 92% of the 716 pharmacies in Wales. This system enables pharmacists to access or receive information from a number of Welsh NHS portals, including access to: Welsh Demographic Service for the Common Ailment Service and the Emergency Medicine Supply service, electronic discharge advice letters (e-DAL) for Discharge Medicine Review services, sent directly from secondary care to the pharmacy; read access to the Welsh GP Record for the Emergency Medicine Supply service.

Electronic Medicines Optimisation Pathway, Hertfordshire
Hertfordshire and West Essex Sustainability and Transformation Partnership has recognised the benefits of electronic transfer of discharge information from a hospital pharmacy to a patient's nominated community pharmacy. With the support of the Eastern Academic Health Science Network and the Local Pharmaceutical Committees, an electronic system has been set up so that medication information is sent to a patient's pharmacy of choice upon discharge so that pharmacy can consider offering a Medicines Use Review or New Medicines Service.

Digital Minor Illness Referral Service
Further rollout of the Digital Minor Illness Referral Service, currently being trialled and evaluated across four areas in England, will be a significant enabler in helping support people to stay healthy and manage their own minor illnesses, with the support of their local community pharmacy team.

Case study sources include:

Community Pharmacy Future (2011-2018) http://www.communitypharmacyfuture.org.uk/

National Association of Primary Care (2018) Primary Care Home: community pharmacy integration and innovation https://napc.co.uk/wp-content/uploads/2018/05/Community-pharmacy.pdf

Pharmacy Voice (2017) Tackling high blood pressure through community pharmacy https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/693902/PV_Blood_Pressure_Report.pdf

Pharmacy Voice and Pfizer Healthy Partnerships (2016-17) Talking Point: Best practice in community pharmacy (available on request)

[1] https://www.macmillan.org.uk/_images/doncaster-pharmacy-direct-chest-x-ray-referral-project-summary_tcm9-313534.pdf
[2] http://abstracts.ncri.org.uk/abstract/community-pharmacy-referrals-project-increasing-awareness-and-early-diagnosis-of-respiratory-disease-via-a-direct-pathway-to-secondary-care-3/
[3] https://napc.co.uk/wp-content/uploads/2018/05/Community-pharmacy.pdf
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