Response

Department for Health and Social Care Major Conditions Strategy: call for evidence

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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. The CCA membership includes ASDA, Boots, LloydsPharmacy, Morrisons, Rowlands Pharmacy, Superdrug, Tesco, and Well, who between them own and operate around 6,000 pharmacies, which represents nearly half the market. CCA members 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.

Cardiovascular Disease (CVD)

1. **In your opinion, which of these areas would you like to see prioritised for CVD? (Select up to 3)**

   - Preventing the onset of CVD through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)
   - Stopping or delaying the progression of CVD through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)
   - Getting more people diagnosed quicker
   - Improving treatment provided by urgent and emergency care
   - Improving non-urgent and long-term treatment and care to support the management of CVD

2. **How can we successfully identify, engage and treat groups at high risk of developing CVD through delivery of services that target clinical risk factors (atrial fibrillation, high blood pressure and high cholesterol)? (Please do not exceed 500 words)**

   Since October 2021, eligible people have been offered NHS blood pressure checks at their local pharmacy, without the need for an appointment. Between October 2021 and October 2022, pharmacies provided just over 590,000 blood pressure checks. Subsequently, 25,500 ambulatory monitoring consultations were provided, totalling over 600,000 interventions. Over 44% of these blood pressure checks took place in the 30% most deprived communities, improving health outcomes amongst those who traditionally do not engage with other NHS services.

   Our projections suggest community pharmacy could provide approximately 15 million blood pressure screenings over five years (2021-2026). Based on this forecast, community pharmacies could detect over 650,000 cases of high blood pressure over this time period. Early detection is critical to good outcomes. By identifying people earlier, the work of community pharmacies will help save lives. After being identified by community pharmacies, GPs can ensure patients receive the appropriate treatment. Over five years this will prevent up to 15,000 cardiac events – 8,800 strokes and 5,800 heart attacks.

   The wider roll out of independent prescribing in community pharmacies in England, this could mean that patients are tested and treated with prescribed medication on a walk-in basis within community pharmacies. This will provide a more timely and convenient diagnosis than the traditional route through General Practice.

   There are an estimated 7 million people diagnosed with ‘high' blood pressure and receiving monitoring or treatment by their GP. With investment, the care for many of these patients could be transferred to community pharmacy, increasing the capacity of general practice for more complex patients, whilst providing a more convenient and local service for patients.

Chronic Respiratory Disease

3. In your opinion, which of these areas would you like to see prioritised for Chronic Respiratory Disease? (Select up to 3)
    - Preventing the onset of CRDs through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)
    - Stopping or delaying the progression of CRDs through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)
    - Getting more people diagnosed quicker
    - Improving treatment provided by urgent and emergency care
    - Improving non-urgent and long-term treatment and care to support the management of CRD

Dementia

4. In your opinion, which of these areas would you like to see prioritised for dementia? (Select up to 3)
    - Preventing the onset of dementia through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)
    - Delaying the progression of dementia through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)
    - Getting more people diagnosed quicker
    - Improving treatment provided by urgent and emergency care
    - Improving non-urgent and long-term treatment and care to support the management of dementia

Musculoskeletal Conditions

5. In your opinion, which of these areas would you like to see prioritised for MSK? (Select up to 3)

    - Preventing the onset of MSK through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)
    - Stopping or delaying the progression of MSK through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)
    - Getting more people diagnosed quicker
    - Improving treatment provided by urgent and emergency care
    - Improving non-urgent and long-term treatment and care to support the management of MSK

Tackling risk factors for ill health

6. **How can we support people to tackle these risk factors? (Please do not exceed 500 words)**
   You might consider suggestions on how we could:

- make changes at a local level to improve the food offer and support people to achieve or maintain a healthy weight and eat a healthy diet
- identify and support inactive people to be more physically active
- support people to quit smoking, including through increasing referrals to stop smoking support and uptake of tobacco dependency treatment
- support people who want to drink less alcohol to do so

The community pharmacy network is a unique exception to the inverse care law, and pharmacies are disproportionately located in areas of higher deprivation.

Services commissioned through community pharmacies mean that they can act as an essential health and wellbeing hub for patients who may be less likely to visit another healthcare setting. As well as the convenience of locality, pharmacies are often open longer hours and at weekends when other local healthcare settings may not be available. Since certain conditions are more prevalent among deprived communities, the accessibility of community pharmacies could be further capitalised on by tailoring service commissioning to meet the needs of the local population.

Smoking

For example, smoking accounts for approximately 75,000 deaths and costs the NHS £2.6bn annually, the existing network of 11,000 community pharmacies could and should be better used to help people quit smoking.

The Government should consider commissioning a national stop-smoking service to be provided by community pharmacies. Whilst many colleagues are trained to deliver smoking cessation support, there is no nationally commissioned patient-led service. This postcode lottery of commissioning reduces uptake by pharmacies, many of whom operate on a national footprint, and therefore reduces access for patients.

A single national service specification would ensure that patients across the country can access equitable care and bring significant benefits to the NHS by reducing prevalence of smoking-related diseases such as CVD and lung cancer.

Weight

As part of a weight management service, community pharmacy teams can initiate discussions with people about the health risks associated with being overweight or obese. Where consent is given, simple tests such as BMI and waist measurements can support the provision of tailored advice and discussions about factors including eating behaviour, co-morbidities, medication, and psychological problems. A personalised action plan with goals for weight management can be used by the pharmacy team to provide ongoing monitoring and empower patients to improve their own health and wellbeing.

Raising awareness among the public and other health professionals about the services that community pharmacies provide, including through the Healthy Living Pharmacy (HLP) framework, can ensure that those wishing to access weight management advice can get the information and services in a setting that is most convenient to them. As a result, this may help patients from deprived communities manage concerns about their weight and reduce associated health inequalities.

Supporting those with conditions

7. **How can we better support local areas to diagnose more people at an earlier stage? You might consider suggestions to increase capacity available for diagnostic testing or identify people who need a diagnosis sooner.**

   As mentioned in questions 2 and 6, community pharmacies offer a range of testing services such as blood pressure monitoring, weight measurements, blood glucose measuring and oxygen saturation testing.

   The Government and the NHS should consider commissioning diagnostic activities such as these on a national level, which can improve access and remove simple caseloads from General Practice.

8. **How can we better support and provide treatment for people after a diagnosis? You might consider suggestions that help people to manage and live well with their conditions, with support from both medical and non-medical settings.**

9. **How can we better enable health and social care teams to deliver person-centred and joined-up services? You might consider suggestions to improve the skill mix and training of the health and social care workforce.**

   Whilst we welcome the additional recruitment of staff into the primary care sector, the Hewitt Review notes that the recruitment of pharmacists and pharmacy technicians into Primary Care Networks (PCNs) through the Additional Roles Reimbursement Scheme (ARRS) has exasperated workforce shortages within the community pharmacy sector. The CCA would like to a more joined up approach to workforce, which considers the needs of the whole system.

   To address the current situation, local systems could commission community pharmacies to deliver specific "packages of care" on behalf of PCNs, rather than relying on the movement of people from points of access to places with challenges on space and capacity. This would not only better utilise the extensive community pharmacy network and minimise disruption to the wider system, but it would build patient access to care in highly accessible settings and promote integration across different providers of NHS services.

   In addition, we must make greater use of the skills mix within pharmacy teams to free up clinical capacity. This will allow for each step of the dispensing process to be carried out by the most appropriate member of the team, improving operational efficiency, whilst maintaining patient safety, and releasing the clinical capacity of the pharmacist.

   At present, this is hindered by out-dated legislation (commonly referred to as 'supervision'). The Government should implement changes to supervision, freeing up pharmacist time to provide patient-facing care, as well as other efficiencies committed to as part of the current CPCF.

10. How can we make better use of research, data and digital technologies to improve outcomes for people with, or at risk of developing, the major conditions?

Technical and data standards are essential to enable interoperability across the entire health system. This will allow a healthcare professional to have access to the most up to date information to provide efficient and effective clinical care to a patient.

Standardised data collection is also important to identify local priorities for care, support better health outcomes and health inequalities. Community Pharmacy has the potential to further contribute to local priorities by having access to local population health data. This would allow pharmacies to work with and understand individual PCN priorities in a coordinated way to deliver integrated care to a local patient population. This could be enabled by gaining full access to the Strategic Health Asset Planning and Evaluation (SHAPE) population health database.

In addition, we believe primary care data access should be further developed to share more CP service outcomes into the GP record. This would reduce the administration burden for both pharmacy and GP colleagues and enable efficient and seamless clinical communication across the wider health system. In turn this would allow clinicians access to the information they need to deliver care in a way that is seamless for the patient.

As part of the CPCF, the GP Community Pharmacy Consultation Service relies on digital referrals from a GP into community pharmacy, to treat patients for low acuity conditions. However, referral systems used in localities do not currently follow a nationwide technical standard which means different systems require checking for patient referrals based on the system chosen. This leads to operational inefficiencies and takes pharmacy teams away from providing other value adding services to patients.