ROYAL PHARMACEUTICAL SOCIETY
England

Developing the Long term Plan for the NHS
Royal Pharmaceutical Society submission

1. **What are the core values that should underpin a long term plan for the NHS?**
We understand that the NHS needs to be able to deliver the best value for money that it can within the resource constraints it has. The NHS needs to focus on what delivers the best outcomes for patients and the best return on investment related to those outcomes. It is vital that the NHS focuses on best value for money and not just cost of service to deliver the best possible outcomes for citizens. Alongside the core values there should be a review of access to services which should take into consideration technology, cost-effectiveness and consistency of quality.

   The NHS should ensure that the capability of all healthcare professionals is used to its fullest. In the past, pharmacists have often been overlooked. Pharmacists are highly educated to master's degree level, and through access to post graduate foundation training programmes should be continually developed throughout their career in both generalist and specialist areas of practice as an integral part of the NHS workforce.

   Medicines are one of the most common interventions in the NHS and are the second highest cost to the NHS after salaries. The NHS wants to ensure the best value from the investment it makes in medicines and pharmacists are critical to making this happen. Because of this, pharmacists should be involved in system leadership to ensure the optimisation of medicines is consistently considered in all health economies.

   The NHS also has a key role to play in global health matters and is playing a leading role in medicines safety and antimicrobial stewardship. Yet again, these are two major areas where the involvement of pharmacists can make a significant difference.

   In terms of people and patients, the values in the NHS Constitution should underpin the long term plan for the NHS. The NHS needs to be truly person-centred and all discussions with the person or their carer need to be based on shared decision making principles. This means a change in culture from both healthcare professionals and people / patients themselves. The services within the NHS should be co-designed with the patients that use them. People should be empowered to self-manage their conditions and there is a need for a significant focus on prevention such as making every contact count. Pharmacists already have a key role in this and should become even more involved in the future.

   There should be genuine partnership working between health and social care and a parity of esteem between physical and mental health.

   Primary care service provision extends beyond general medical practice and includes those providing services outside of the GP practice team including community pharmacies, optometrists and dentists as well as others delivering services in the community and this needs to be continually recognised. NHS England must take a leadership role in ensuring that conversations about primary care include all of the resources available to the system (including pharmacists in settings such as community pharmacy, care homes and general practice).

2. **What examples of good services or ways of working that are taking place locally should be spread across the country?**
There needs to be more investment in robustly measuring, the outcomes and values that services deliver. Where there is evidence of good practice there needs to be ways of replicating and spreading this nationally and this should help to reduce some of the inequalities that currently exist. The NHS should build on what currently works well.

In order to make this happens there need to be cultural changes and financial support including investment in the people delivering the services. The successful roll out of NHS Urgent Medicine Supply Advanced Service (NUMSAS) and also the Pharmacists in General Practice scheme have shown that successful local services can be rolled out effectively and efficiently if enough investment is made to achieve spread of innovation.

Some examples that should be rolled out across the country are included as **Appendix 1.** The examples included are in no particular priority order but all of them are happening somewhere in the country and could be replicated and spread across the country to improve patient care and to ensure that the NHS is getting the best value from the pharmacy workforce.

3. **What do you think are the barriers to improving care and health outcomes for NHS patients?**
One of the main barriers is the lack of integration between health and social care, and although the Sustainability and Transformation Partnerships and Integrated Care Systems are going some way to address this, there needs to be shared objectives and shared funding to make it happen in reality. Currently incentives are not aligned to deliver transformation and this needs to change. The culture and relationship between the different primary care contractors needs to be better aligned and there needs to be agreement of ownership.

As outlined above, medicines are one of the most common interventions made in the NHS. Pharmacists need to be included in system leadership to ensure that the NHS gets the best value from the investment it makes in medicines and to ensure that patients get the best possible outcomes from those medicines. In order to support this there needs to be more investment in workforce development for pharmacists to help them continue, post registration, to become science based clinicians. Investment in a national foundation programme for pharmacists can ensure more consistency in practice post registration.

In addition there needs to be more of a focus on self-care and supported self-management within the system. Prevention of disease needs to be a much stronger focus and community pharmacists have a significant role to play in this area. A recent report on community pharmacy clinical services[1] recommended that smoking cessation should become a nationally commissioned community pharmacy service. Despite the responsibility for public health sitting with local authorities the NHS must do more to support individuals to live healthier lives through interventions such as smoking cessation, obesity services, sexual health and the like.

[1] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf

Opportunities to use training hubs to really provide multidisciplinary learning and deliver more efficient one stop care should be explored.

The current interoperability of digital systems makes it hard to deliver care in all settings that the patient accesses. Systems need to become interoperable and patients need to own and access their records so they can make decisions about who can view their record to help support their care.

Whilst the NHS needs to work at a local level to identify local priorities and ways of working this can also cause problems as it leads to a mismatch of services and it is not always clear what is available to whom and from where. There does need to be some national consistency so that awareness of certain services can be raised with patients and the public.

Life stage Programmes:

1.1 What must the NHS do to meet its ambition to reduce still-births and infant mortality?

Community pharmacies provide accessible healthy living advice during a woman's pregnancy, including advice on alcohol, healthy weight, smoking and folic acid supplementation. Women already taking medication for long-term physical and mental health conditions can also find out whether they can continue their regime or whether they might need to change their medicines. Better utilisation of community pharmacies could help the NHS reach its ambition in this area.

In the hospital setting, pharmacy advice to maternity services is vital to ensure that the very precise medicine regimes needed to support babies and mothers perinatally and in the first few months of life are there for patient safety. For example, although many mental health medications can be taken by pregnant women right through to birth, babies may be born with temporary syndromes and staff must know what to look for. An example is persistent pulmonary hypertension of the newborn (PPHN) which can occur in newborn babies of women taking fluoxetine, a common antidepressant. Specialist pharmacy advice is also vital on NICU to support multidisciplinary staff to maintain patient safety and precise dosing of medicines for babies needing acute care.

Health visitors and institutional childcare staff can use community pharmacy as a resource when advising mothers how to treat minor ailments for babies and infants safely. Commonly used medicines like liquid paracetamol have doses that change from birth through to age 16, and parents must carefully note the right dose for each age range – and how to use a medicine syringe accurately - or devastating and potentially lethal adverse drug reactions can occur. Pharmacists can also give advice on the safe storage of medicines in a family home. We know that accidents in the home are a major cause of morbidity and mortality in infants and young children.

1.2 How can we improve how we tackle conditions that affect children and young people?

In order to halt the rise of non-communicable diseases in children and young people, effective prevention and treatment strategies must be in place. There are many different opportunities for

connecting with children, young people and families and we must engage stakeholders in different settings, including nurseries, schools, youth organisations (e.g. scouting), further/higher education and employers.

If these conditions are prevented, or if that is impossible, that they are treated effectively from childhood and adolescence, then future demands from adults with long-term complications due to poor condition control will ease. Pharmacists providing an inhaler technique check service in Greater Manchester note that most adult users said they had had their inhaler since childhood without initial advice. This prompted a pilot intervention with students in primary and secondary schools where evaluation results included some students then being able to participate in sport and exercise, which will help them to avoid multiple morbidities later in life.

Prevention

Health and taking care of yourself should become part of school curricula to help educate people at a young age to self-care. Education of parents about health and the links between health and diet, exercise, smoking and alcohol should happen so they can help and support their children to lead a healthy lifestyle.

There should be standardised and consistent public health campaigns across the country in pharmacies, GP surgeries, libraries and other places that the members of the public access.

Structural interventions such as banning smoking in public spaces and implementing the 'sugar tax' has helped young people to avoid risky behaviours. Similarly creating plentiful free and safe public spaces for play and exercise will help families to keep active. Pharmacists in these communities can give consistent messages about healthy lifestyles as outreach to families who might not otherwise come into contact with formal health services. All health professionals in the NHS should act as advocates for children, young people and families on these topics of huge social importance.

Treatment

Children and young people living with long-term conditions have the same rights as others to complete their education, find employment and housing, and have successful relationships. But they often find it more difficult to do all of these things than their 'healthy' peers. The input of pharmacists as part of the multidisciplinary team can be instrumental in improving outcomes as medicines are a key element of most treatments. Research funded by Pharmacy Research UK showed that young people linked their medicines and condition to their forming identity, and that successful condition management could only happen if health professionals considered treatment in the context of their daily lives[2]. Taking medicines at school or work is very difficult, safe spaces for administration and fear of disclosure may lead to non-adherence. Thoughtful reviews of medicines to avoid daytime dosing through the use of long-release preparations, for example, may be effective pharmacy interventions tailored to the needs of the child or young person.

Research supported by Pharmacy Research UK has shown that pharmacists in community and hospital settings have complementary opportunities to support children and young people with long-term conditions[3]. For example, hospital pharmacists can help with the prescribing,

[2] http://pharmacyresearchuk.org/wp-content/uploads/2013/07/Arthriting-3-page-executive-summary-12dec13.pdf

[3] http://pharmacyresearchuk.org/wp-content/uploads/2016/05/NG-Arthiriting-Exec-Summary-Report.pdf

administration and supply of specialist treatments. Hospital pharmacists may run specialist paediatric clinics, one example includes teaching injecting skills for young people needing subcutaneous methotrexate. Community pharmacy has the opportunity to form a long-term trusting relationship with families so that when children and young people come to the point of transfer of care from paediatric services to adult services they know that their community pharmacy is a constant, and that their other health professionals have a point of contact for them and their medicines. Community pharmacists can also act as navigators of health systems, building generic health skills such as submitting repeat prescription requests, in turn increasing the health literacy of this population. Pharmacists in general practice settings can provide a conduit for communication and another opportunity to review medicines. Effective information flows, however, and shared read/write electronic records for pharmacists in all settings are needed to make this possible.

Community pharmacies are an ideal location close to home to undertake physical monitoring of children and young people who would otherwise have to travel to specialist centres, which entails days missed from school for children and young people and from work for family members. For example, the physical health monitoring of children with ADHD was undertaken in Sussex community pharmacies, which was appreciated and used by children with ADHD and their families and was also a cost-effective way of providing the service.

1.3 How should the NHS and other bodies build on existing measures to tackle the rising issues of childhood obesity and young people's mental health?

At the moment the NHS is a service that only engages people when an emerging problem is suspected or has already occurred. A more proactive life course approach is needed where children, young people and families are engaged and aware before the problems begin.

Most mental health conditions emerge with their first symptoms in adolescence. Community pharmacy may be able to identify young people at risk of mental health problems if they come to buy non-prescription medicines such as sleep aids or herbal remedies for low mood. Support for parents of young people with mental health problems is also important and pharmacy can help with their needs.

Better utilisation of the pharmacy workforce will help with both prevention and early detection of both obesity and mental health issues. Pharmacists can play a significant role in helping to educate the public. If the pharmacy workforce was trained they could become outreach system navigators for younger people to find help and advice and also onward signposting for their mental health issues.

Better use of digital solutions such as game playing through the use of apps that children can engage with could support children in both obesity and mental health.

It is vital that the safest possible medicines are used for children and young people with mental health issues and this can be supported by specialist pharmacy services using specialist mental health pharmacists. Mental health medicines can precipitate temporary side-effects, and the overall plan and timescale of treatment must be explained and reinforced to avoid discontinuation at an early stage. Visiting a community pharmacist for a New Medicines Service (NMS) consultation could provide an opportunity to keep young people engaged and give them a readily accessible professional in those first crucial weeks.

Mental health literacy should be embedded into all areas of the NHS and all healthcare professionals should understand mental health issues. There are many third sector organisations with extensive expertise in this area and their insights should be sought.

Young people living with mental health issues and other long-term conditions need to work with the NHS to co-create safe spaces for prevention and treatment activities that are developmentally appropriate and rooted in the lived experience of service users.

1.4 How can we ensure children living with complex needs aren't disadvantaged or excluded?

Include this element in teacher training nationally so all teachers are aware and treat children with complex needs in the appropriate way. In particular there should be a focus on the responsibilities of school teachers with SEND (special education needs and disabilities). There should be further investment in education to ensure better integration.

Children with complex needs should have a personalised care plan and this should include a single point of contact to a health and social care multidisciplinary team.

Services for such children should be provided locally and use of existing networks, such as community pharmacies, should be better utilised to provide support and care.

Pharmacists who are specialist in a particular area could help to provide integrated medicines support by linking with local GP practices, care homes and community pharmacists to deliver comprehensive care closer to the person's home and outside of the hospital setting.

Shared care records e.g. Professional Record Standards Body (PRSB) Healthy Child Record, are a really important part of this and require electronic interoperability and clinical data / record standards to work. These records ensure that information on specific needs and reasonable adjustments are available to all stakeholders across health, care and education.

Engaging children and young people with complex needs, and their families, in the development of services is crucial in order to achieve meaningful improvements.

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

Pharmacists working in all care settings across the system can play a role in prevention. There are some fantastic examples of community pharmacists providing public health services such as weight management, smoking cessation, sexual health etc.

One of the major issues the NHS currently faces is the obesity crisis. Pharmacists can really make every contact count as they often see people who are not accessing the pharmacy just to pick up medicines or seek advice. This provides community pharmacists and their pharmacy team to have opportunistic conversations with people coming into the pharmacy and to provide brief interventions where appropriate.

The better detection and supported self-management of long term conditions such as cardiovascular disease, type 2 diabetes and respiratory disease can slow progression and ensure

early interventions are undertaken, including lifestyle choices. Pharmacists are in a great position to do this. Appendix 1, Example 6 shows the impact community pharmacists are having in detection of Atrial fibrillation.

There also needs to be investment in mental health services across all ages as many physical conditions can be a result / consequence of a mental illness and conversely, around 30% of people diagnosed with a long term condition suffer from depression.
In order to provide better prevention services the workforce need to be upskilled in health literacy so that they can provide the right support to the people they are interacting with. Pharmacists are becoming increasingly involved in all aspects of the care of patients and are ideally placed to improve health literacy in communities across the country.

Community pharmacies are easily accessible to patients and the public and the majority of the population can access a community pharmacy within a 20 minute walk and crucially, access is greater in areas of highest deprivation — a positive pharmacy care law.[4] Community pharmacists should be actively commissioned to deliver NHS Healthchecks and other prevention services working closely with other members of the primary care team.

Community pharmacists often see people when they are well so there is a huge opportunity to support people at an early stage and also to detect signs and symptoms of a long term condition at an early stage.

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?

Incentives are needed to ensure that prevention is included as part of the system and not seen as something outside of the NHS. All levers that are available to do this should be utilised, including contractual levers. The prevention agenda needs to be linked up across all of primary care and also other care settings. Opportunities for prevention interventions across health and non-health settings should be maximised. Public health funding currently sits within local councils and many are focusing on population level interventions. Whilst RPS fully supports population level public health interventions this has meant that individual public health services such as stop smoking have not seen the continued investment necessary. The NHS must fill this gap if we are to prevent further health burdens from factors such as smoking, obesity, inactivity and alcohol.

Healthcare professionals including pharmacists need to be supported to deliver person centred care including how to have real shared decision making conversations and how to understand and adjust conversations for health literacy. There needs to be a multi-agency approach to public health targets.

Health records and information must be easily accessible for all health and care professionals including pharmacists when they need it and are providing care for patients in all the settings they

[4] https://bmjopen.bmj.com/content/4/8/e005764

work in. There needs to be co-ordinated actions to ensure a safe handover when patients transfer across different care settings.

There needs to be a focus on reducing the 15-20 year gap in life expectancy for people with a serious mental illness by improving physical healthcare for these people.

As primary care networks develop it needs to be ensured that all contractor services are equally represented and involved in planning services fit for their communities. Care should be integrated across all settings and better use should be made of multidisciplinary models of care. Integrated care provider contracts should be put in place to ensure that prevention is built into strategic considerations as part of a whole and long term solution. This will mean that prevention, early detection, treatment and management, urgent care and support for independent living is coordinated. Commissioners should invest in programmes that support longer term adherence to medicines to ensure patients get the most from their medicines as well as having a focus on the optimisation of medicines that are known to cause mortality and morbidity.

People and patients also need to be encouraged and supported to take more responsibility for their own health. Schemes should be developed which empower patients and the public to optimise their own opportunities to improve their health and understand the care they should be receiving.

1.7 What should be the top priority for addressing inequalities in health over the next five and ten years?

Existing resources, such as the community assets of pharmacies, need to be used more effectively and there should be particular attention paid to those in the most deprived areas.

There needs to be a focus on mental health treatment and improving the physical healthcare for people with a mental health problem. More needs to be done to join up working with social care to reduce the significant health inequalities in deprived areas.

There should be more outreach care to enable those living independently but who have complex issues to remain at home where appropriate. For those living in care homes or who are housebound there should be the equal access to all healthcare services as any other member of the public, for example access to a domiciliary medicines use review by a pharmacist.

Currently QOF exception reporting can be used due to inaccessible service delivery i.e. the person cannot access the service. Services should be redesigned, using all of the available workforce including pharmacists, to ensure that they are accessible.

There should be a focus on community development and local access to services, including pharmacy services, as part of an overall integrated service. There should be an increase and expansion in social care prescribing and this should facilitate the use of community pharmacists to socially prescribe.

Health information is widely available through a variety of sources, but these sources are not always reputable. We need to be able to help patients to understand the information and what it means for them as an individual.

People are accessing healthcare differently and are starting to use digital aids such as fitbits. This could cause a widening in the health inequality gap and care needs to be taken to address this.

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

Please see Appendix 1

In addition we believe that NHS Healthchecks should be commissioned nationally via community pharmacies. Services that are already part of the contractual framework for community pharmacies should be integrated into care pathways for those patients with long term conditions, such as medicines use review (MUR) and new medicine service (NMS). We also believe that the NMS should be extended to other conditions as it has been shown to increase adherence to medicines by 10%,[5] and suggests £75.4m short-term savings to the NHS, £517.6m long-term cost savings to the NHS and 179,500 QALYs gained. A service similar to this should be offered to all patients prescribed an anti-depressant for the first time.

The clinical handover when a patient is discharged from hospital is a critical time in terms of medicines optimisation. Many Academic Health Science Networks (AHSNs) have implemented an initiative where hospital pharmacists refer patients to their local, regular community pharmacist on discharge. The community pharmacist is then aware of any changes to the patient's medicines and can follow these up with the patient via an MUR or other service. This is already being implemented in many areas but this should be accelerated.

1.9 How can personalised approaches such as paying attention to patient activation, health literacy and offering a personal health budget reduce health inequalities?
People need to be engaged in their health in order to change behaviour. They also need to be able to understand how to manage their health and their medicines. Pharmacists have a significant role to play in supporting patients to understand their medicines and how they help to keep people healthy.

In Cornwall 20 community pharmacies were commissioned to provide a patient activation service to patients with type 2 diabetes with the goal of improving clinical outcomes for these patients. 98% of patients recruited into the service achieved or partially achieved their goals over a 3 month period and PAM scores increased in 77% of patients with a mean increase of 8.64 PAM points. Based on national evidence this relates to an increase in patient's ability to manage their own condition by improving their lifestyle and self-management and result in up to an 18% reduction in hospital admissions.[6]

1.10 What is the best way to measure, monitor and track progress of prevention and personalisation activities?
There is currently quite wide use and promotion of digital technologies which measure, monitor and track progress and this should be further encouraged. The use of apps and other handheld tools can empower patients and help them to be more involved in their own health. However, this

[5] https://www.pharmaceutical-journal.com/news-and-analysis/news/new-medicines-service-could-save-nhs-5176m-economic-evaluation-finds/20203374.article?firstPass=false
[6] http://www.swscn.org.uk/networks/cardiovascular/diabetes/patient-activation/

could cause a widening in the health inequality gap between those who can spend money on such devices and those that cannot.

Robust evidence in practice needs to be collated and shared.

Pharmacies could be commissioned to deliver more point of care testing along with advice and support to people accessing pharmacy services.

There needs to better use of digital health systems, better use of community pharmacy services and an increased investment on practice research to increase the evidence base and enable informed decision making.

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?

Patients need to be supported to understand their medicines and the risks and benefits of taking them via the conversations and consultations they have with their pharmacists. As primary care networks develop they could ensure that medicines optimisation services, such as medicines use reviews and new medicine services are part of strategic care pathways.

Patients should have greater control over their data and records so that they can approach more people to help them with their medical and health issues.

Patients should be supported to make informed decisions about their health and treatments via supported self-management methods. Encourage patients with long term conditions to be involved in local groups who provide peer support.

Fully include patients in decision making bodies and processes.

Support both healthcare professionals and patients to communicate better whilst recognising health literacy.

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?

The majority of people with complex needs will be taking at least one medicine so pharmacists, as experts in medicines and their use, should be part of the multidisciplinary team in every care setting. All multidisciplinary teams supporting and managing people with complex needs should include a pharmacist who would have a specific remit including medicines safety. Recognition of good models of multidisciplinary work should happen and be rewarded. There should be a clear focus on supporting development and career pathways for pharmacists in multidisciplinary teams so that generalism within the profession is rewarded. Pharmacists should play a greater role in preventing confusions, recognising and managing cognitive decline and reducing falls by optimising medicines for individual patients. To support this expansion of work it is important that there is investment in pharmacists during their foundation years.

Contracts need to be aligned so healthcare professionals and social care are encouraged to collaborate and not be in competition, this could be achieved, for example, by having a primary care network contract where all professionals are working to achieve the same outcomes for

patients and the NHS. And primary care needs to include all those working in primary care and not just focus on GP practices.

The hierarchy that currently exists in many multidisciplinary teams should be removed so that all members of the team have equal importance.

Both mental and physical healthcare must be treated at all stages of frailty.

Health records need to be shared and available to anyone providing care for that particular patient, with patient consent. This will facilitate safe handover.

There should be more education on signs and symptoms that lead to a crisis.

1.13 What would good crisis care that helps prevent unnecessary hospital admissions for older people living with various degrees of frailty look like?

The majority of older people living with a degree of frailty will be on at least one medicine. Pharmacists, as experts in medicines and their use, can support patients to take the medicines that are appropriate for them, to get the best outcomes from their medicines and thereby reducing unnecessary hospital admissions. It has been shown that pharmacist led medicines reviews can provide savings to the NHS as well as improving care for patients. One project in Brighton and Hove concluded that pharmacist-led medicine reviews in care homes could save £190 per resident by avoiding an unplanned hospital admission. When applied to the number of care home residents on medication, this equates to potential savings of over £75 million per year in avoidable hospital admissions.[7]

This also relates to people living independently at home – pharmacist led medicines reviews could help prevent hospital admissions. Such reviews provided by pharmacists should be integrated into care pathways and commissioned as part of integrated primary care services.

Integrated pharmacy teams that work across primary and secondary, as in the Northumbria model[8] support frail older people in a number of ways:

- Identifying and stratifying patients who are frail and at risk of medicines related harm (e.g. polypharmacy) and then supporting them with making the right decisions about medicines. Pharmacists can support preventing patients from moving across frailty thresholds.
- Rapidly reviewing patients when they have a crisis; a MDT approach to supporting them to stay out of hospital.
- Integrated pharmacists being available to support in times of crisis e.g. Flu pandemic – support vaccination, antivirals, front of house review, etc.

One example from Northumbria is a 89 year old lady admitted to A&E following an epileptic fit. Assessed on A&E: decision to increase Lamotrigine. Discharged back to care home. Integrated pharmacist liaised with A&E and prescribed from GP system, working with Community Pharmacy, who supplied the medicine. Admission to ward avoided

[7] https://www.rpharms.com/making-a-difference/projects-and-campaigns/pharmacists-improving-care-in-care-homes

[8] https://www.pharmaceutical-journal.com/research/perspective-article/impact-of-an-integrated-pharmacy-service-on-hospital-admission-costs/20204550.article?firstPass=false

Enabling all healthcare professionals to have access to the appropriate patient information at the point at which they provide care would also help to reduce admissions as everyone would have the complete and accurate picture of care that had been provided to date and could then make more informed and accurate decisions on further action that may be required.

Mental health home treatment models should be expanded across the country and the teams should include a specialist mental health pharmacist. These teams provide intensive home based therapies and support as a safe alternative to admission as an inpatient.

1.14 What would be the right measures to put in place to know that we are improving patient outcomes for older people with various degrees of frailty?
One of the measures could be a reduction in hospital acquired infections.

Another measure could be a regular review and optimisation of medicines, including deprescribing of unnecessary medicines. Obviously this would be part of a shared decision making consultation.

A further measure could focus on the quality of life of people with frailty by asking 'what matters to you'. In terms of medicines this could be part of a holistic medicines review to minimise medicines burden and risk.

Reduction in hospital admissions would also be a positive outcome

And lastly the body of evidence for better, evidence-based, shared decision making needs to be increased.

1.15 How can we ensure that people, along with their carers are offered the opportunity to have conversations about their priorities and wishes about their care as they approach the end of their lives?
Improvement of communication and consultation skills for healthcare professionals should enable and facilitate this. People and their carers should also be aware that these opportunities are open to them and be encouraged to take them up. Many pharmacists have developed these skills but more investment in workforce development would further improve these conversations.

1.16 What are the main challenges to improving post-diagnostic support for people living with dementia and their carers, and what do you think the NHS can do to overcome them?
One very simple solution would be to ensure that all healthcare professionals coming into contact with the person who has dementia are aware of their diagnosis so can provide appropriate care and support.

Treating people with dementia as individuals and not talking 'around' them but with them and involving them, where possible, in decisions about their care.

Making sure that all healthcare professionals understand the challenges that dementia brings and providing them with the tools and knowledge so they can deal with them.

Having both mental and physical healthcare available wherever a person with dementia is presenting for help.

The taking of multiple medicines is often a major challenge for those with dementia and their carers. There should be regular pharmacist led medicines reviews with people who have dementia.

1.17 What is your top priority to enhance post-diagnostic support for people living with dementia and their carers?
Making all services and environments within the NHS 'dementia friendly'.

The NHS also needs to work closely with care homes (nursing and residential) to look at how both residents and carers can be supported to improve healthcare needs.

Ensuring contracting models for services provide the ability and resources for health care professionals such as pharmacists to spend more time with people with dementia and their carers.

Clinical Priorities

2.1 What should the top priority for improving cancer outcomes and care over the next five and ten years be?
One of the top priorities should be the involvement of all of primary and community care, including pharmacists, in early detection and ensuring there are methods to directly refer to specialist services where appropriate.

Developing informatics to support genomics would enable accurate typing of cancers, personalisation of chemotherapy and reporting of outcomes. Developing informatics to support and report personalised chemotherapy would be a huge move forward and should be a priority.

2.2 What more can be done to ensure that:
a) More cancers are prevented?
b) More cancers are diagnosed early and quickly?
c) People can maintain a good quality of life during and after treatment?
d) People with cancer have a good experience of care?

Utilisation of the community pharmacy network to help identify early signs and symptoms of cancer will help to detect cancers earlier and the establishment of formal referral mechanisms to secondary care or other care settings will ensure a quick referral to those with specialist knowledge and skills.

Build on the developing local integrated care pathways to link primary care pharmacy services, GP practice pharmacists, community pharmacists and local secondary care pharmacy departments to ensure cancer patients have seamless access to medicines support and ongoing care. Cancer teams should in future naturally work and communicate across organisational boundaries which includes local community pharmacy networks.

Ensure community pharmacists have the knowledge and skills to identify adverse effects from oral chemotherapy and ensure formal referral systems are in place so these patients can be referred in a timely manner.

Use of pharmacists to develop cancer care plans.

Having specialist advice available to those working in primary care, such as community pharmacies and GP practices would help.

2.3 How can we address variation and inequality to ensure everyone has access to cancer diagnostic services, treatment and care?
Ensure regional medicine optimisation committees and cancer alliances are empowered to tackle variations in medicines access uptake, e.g. NICE guidance on use of prophylactic tamoxifen has not been widely implemented.

Ensure cancer alliances have access to chemotherapy and pharmaceutical advice and are linked to chemotherapy commissioners. Alliances should fund lead cancer pharmacist sessions to support this.

Ensure pharmacists are included in cancer planning workforce discussions, a number of recent reviews have come out that have not included the pharmacy workforce (hospital and primary care).

2.4 What actions could be taken to further reduce the incidence of cardiovascular and respiratory disease?
There needs to be better prevention services. A review into community pharmacy clinical services recommended that stop smoking services should be nationally commissioned via community pharmacies. Smoking cessation services also need to be inclusive of the smoking of cannabis and shisha.

The Royal Pharmaceutical Society is part of the Lung Health Taskforce and is contributing to the development of the five year plan for lung health which is feeding into the NHS long term plan.

Community pharmacists should be commissioned to deliver early detection of hypertension and atrial fibrillation. To support this, NHS Healthchecks should be promoted and delivered in all community pharmacies.

There needs to be structured respiratory support for all patients who have a respiratory issues via integration of pharmacists into care pathways.

Community pharmacies are already commissioned nationally to provide flu vaccinations and this should be continued and improved. One of the critical developments is the digital communications between the community pharmacy and the GP practice to ensure that patients do not receive more than one vaccination.

A COPD case finding service was provided by 21 community pharmacies in the Wirral area[9]. 238 patients were screened and 135 of these were identified at risk of COPD. Based on the findings from the COPD Case Finding Service, it is estimated that if the service was delivered from 11,100 pharmacies in England to 555,000 patients then the NHS could see benefits of:

- Lifetime savings from stopping smoking of £214.7m, 96,000 life years, and 46,000 QALYs.

[9] http://www.communitypharmacyfuture.org.uk/pages/copd_case_finding_248972.cfm

- Annual benefits of £264.5m (*from diagnosing patients earlier and reduction in productivity costs*).

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?
Pharmacists can provide significant care and support to patients with CVD or respiratory disease and there should be greater support for the development of pharmacist skills post qualification so their role can be further enhanced, particularly in their foundation years.

The community pharmacy network should be used to help identify early signs of respiratory disease, particularly lung cancer and COPD i.e. case finding. Early intervention with lifestyle advice and medicines, where appropriate, should be encouraged. Community pharmacists are already commissioned nationally to deliver Medicine Use Reviews and New Medicine Service, including post discharge and these should be integrated into care pathways for people with CVD or respiratory disease

The expertise of practice based pharmacists should be utilised to review people with CVD and respiratory disease to ensure they are on the appropriate medicines. More time should be provided for a patient consultation so that key aspects of ongoing care can be addressed.

The identification of sub-optimal prescribing practice across both primary and secondary care should be supported and pharmacists should be utilised to do this. Inhaler technique training needs to be promoted nationally and consideration should be given to including this in training courses for all undergraduates.

There should be enhancement and promotion of self-management skills for people with respiratory disease or CVD, providing vital support so that patients can confidently manage their respiratory disease safely. This could be similar to the structured education offered to people who are diagnosed with Type 2 Diabetes.

The NHS should produce clear guidelines for diagnosis and management of both asthma and COPD, ideally one as currently there are both NICE and BTS guidelines.

2.6 What should the top priority for meeting peoples' mental health needs over the next five, and ten years be?
- Better utilisation of the current workforce across all sectors of care.
- More integrated care across all sectors with multidisciplinary teams that includes pharmacists who are experts in medicines and their use.
- Supporting the physical health of people with mental health problems by better utilisation of the pharmacy workforce in primary care.
- Ensure people are supported to understand and take their medicines where agreed as part of a shared decision making process.
- Work to reduce the stigma associated with mental health issues.

2.7 What gaps in service provision currently exist and how do you think we can fill them?
There is currently little or no engagement with the pharmacy profession to help support the delivery of the five year forward view for mental health. This leads to a significant gap in service

provision. Many of the medicines used to treat mental health problems are associated with health risks. As the experts in medicines and their use, pharmacists can ensure people get the best outcomes from their medicines, reduce adverse events, minimise avoidable harm and un-planned admissions to hospital, while ensuring resources are used more efficiently to deliver the standard and level of care that people with mental health conditions deserve.

This gap could be addressed in the following ways:

- Pharmacists are commissioned to deliver physical health monitoring and management of people with mental health conditions. In order to achieve this, all pharmacists directly involved in patient care must have access to IT systems that are interoperable with other primary care IT systems.
- Identify how pharmacists in community settings can be enabled to better support people with mental health problems with their medicines, such as through the inclusion of antidepressants and antipsychotics in a service like the New Medicine Service.
- Every mental health team should have access to a specialist mental health pharmacist as a member of the multidisciplinary team, whether based in community mental health or physical healthcare teams, mental health hospital wards or acute hospitals. This can help improve care for individual patients but can also improve the wellbeing of the wider health care team by having access to more support around medicines.

Effective coordination between pharmacists in different sectors and all other agencies and professionals involved in the care of people with mental health problems needs to be ensured. In particular, more work needs to be done to join up the pathways between specialist mental health services, general practice, care homes and community pharmacy. Community pharmacy access to medical records and the increasing numbers of practice-based GP pharmacists can both play a role in facilitating this.

The Future of the Mental Health Workforce document published in September 2017 by the Centre for Mental Health recognises that pharmacy is sometimes regarded as a peripheral service in mental health but that during their consultation pharmacy was acknowledged to be an untapped resource and that both pharmacists and pharmacy technicians had much to offer

2.8 People with physical health problems do not always have their mental health needs addressed; and people with mental health problems do not always have their physical health needs met. How do you think we can improve this?

Better use of pharmacists will help support the physical health of people with mental health problems.

Physical health monitoring has two components, general physical health monitoring in line with the general population, and physical health monitoring associated with psychotropic or other medicines used in the treatment of mental health problems.

Pharmacists working in all settings can support people with mental health conditions by promoting basic physical and oral health through encouraging exercise and providing services such as smoking cessation services. They also provide advice and services around weight loss and maintaining a healthy weight, healthy living and sexual health.

People with mental health conditions want to be able to access services that are accessible at the right time. Community pharmacists in particular are based centrally in a local community and have an opportunity to make every contact count by engaging people in conversations regarding physical health and wellbeing at every opportunity. Community pharmacists can be encouraged to proactively engage with people with mental health problems and related issues.

EXAMPLE: Patients with a diagnosis for psychotic illness have been receiving physical health checks in community pharmacies through a collaboration between North East London Local Pharmaceutical Committee (NEL LPC), North East London NHS FT and University College London, with support from Public Health London Borough of Barking and Dagenham and the London Mental Health Strategic Clinical Network. Funded by a Health Foundation Innovation Award, patients known to the Barking and Dagenham Community Recovery Team, were offered physical health checks at a local participating community pharmacy. This included ECG, blood pressure, cholesterol and glucose testing with results available on the same day. Pharmacists spent up to an hour coaching patients and empowering them to self-manage their physical health. From September 2016 to January 2018, 180 patients were offered health checks with 140 (78%) taking up the offer. Of all attendees 70% had all five cardiometabolic risk factors monitored which is significantly better than standard care in Barking and Dagenham, where only 36% of patients had all five risk factors monitored and higher than the NHS England national averages for inpatient and community settings.

2.9 What are the major challenges to improving support for people with mental health problems and what do you think the NHS and other public bodies can do to overcome them?

The spectrum of mental health covers a large range of mental health issues. Much can be done to support those with depression, dementia and anxiety in primary care settings.

Better integration and support provided to people who have mental health issues in the workplace.

A key issue with mental health is that while some areas of medical care (e.g. elective hip replacement) are process based and can be managed, to a greater or lesser extent as a pathway, mental health is more intuitive and cannot be boxed into one specific process. So, compared to other specialities, it is harder to support good mental healthcare with IT but certain areas such as prescribing, medicine-related needs and adherence to medicines is where IT can help and support healthcare professionals and patients.

2.10 How can we better personalise mental health services, involving people in decisions about their care and providing more choice and control over their support?

Improve access to specialist mental health pharmacists.
Providing leadership in and assuring the best use of medicines in mental health are the core roles of the specialist mental health pharmacist. Every mental health team should have access to a specialist mental health pharmacist as a member of the multidisciplinary team, whether based in community teams, mental health hospital wards or acute hospitals. A core priority of the NHS mental health programme is to support community services for adults of all ages to deliver high quality, evidence-based interventions which improve outcomes, enable recovery, manage demand and integrate with other local services. Having a specialist mental health pharmacists as part of the core community mental health team will facilitate this.

Many people with MH conditions are taking medicines, both for their mental health conditions but also often for other long term conditions they may also have. Pharmacists, as experts in medicines and their use can take a holistic approach to all the medicines a person may be prescribed, improving the quality of their care by ensuring that they are getting the most from the medicines they are taking. The specialist mental health pharmacists would use their skills and expertise to individualise treatments to get the best outcomes for patients.

The mental health workforce plan for England, published in July 2017, states the need for an additional 10,000 professionally qualified staff within the mental health workforce to enable the NHS to provide a robust service to people with MH conditions. A parliamentary briefing in July 2017 raised this commitment to 21,000 new posts. The training and recruitment of specialist mental health pharmacists should be a core group to target within the 21,000.

2.11 What more can the NHS do, working with its local partners, to ensure that people with a learning disability, autism or both are supported to live happy, healthy and independent lives in their communities?

The STOMP programme should be rolled out so that all people with a learning disability can access their basic rights. The NHS can ensure that positive behavioural support is available to facilitate less reliance on psychoactive medicines.

The NHS should work with employers to ensure better integration and support is provided to people with a learning disability, autism, or both, in the workplace.

Shared care records are beneficial in supporting non-neurotypical people as they make information on additional needs and reasonable adjustments available to all care providers, can help to express the person's wishes and preferences clearly and unambiguously and means that patients don't have to repeat information to lots of different people.

2.12 How can we best improve the experiences that people with a learning disability, autism or both have with the NHS, ensuring that they are able to access the full range of services they need?

Access to specialist mental health pharmacists to ensure complex medicine regimes are personalised and regularly reviewed. Maximising the benefits of medication will develop further health gains. However studies of people with a learning disability, autism or both, of all ages, suggest poor review and management of medication. Some medications are excessively overprescribed (psychotropic drugs) while in other health areas lack of recognition of health needs and poor access to appropriate medication remain a problem.

Many studies have highlighted the reluctance of GPs to reduce the medication without significant expert help. In order to address the need for regular comprehensive medication review we propose the creation of a cohort of clinicians who have specialised in the health needs and review of medications of people with a learning disability, autism or both. These specialised clinicians would be available in all areas to assist general practitioners (GPs) with the annual health check by ensuring that a comprehensive medication review is a key part of it.

Shared care records are beneficial in supporting non-neurotypical people as they make information on additional needs and reasonable adjustments available to all care providers, can help to express

the person's wishes and preferences clearly and unambiguously and means that patients don't have to repeat information to lots of different people – this can be particularly challenging for people on the spectrum.

Enablers

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?

In order to know what workforce is required we need to identify the services and then plan the workforce for the future whilst being aware that this will take several years before they are in place. So we need to look at the existing workforce and all the skills and knowledge within it and see how they can be adapted and used to support the direction of travel that the NHS is taking. It is also vital that we have a digitally literate workforce who know how to use data to improve care.

Currently post registration training of pharmacists is highly variable making it hard to assure quality. As pharmacists take on more complex clinical work we need to ensure they are provided with the appropriate support and training. This will require significant investment and work if we are to get the best return on investment from the pharmacist workforce. Investment will enable more pharmacists to move into more complex roles such as the management of long term conditions in the future. As greater numbers of people live with multiple conditions and have more complex roles we will need the workforce to support them and pharmacists should play a key role in this. In the future we will need more, advanced practice pharmacists as part of multidisciplinary teams and accessible to patients in community pharmacies, GP practices, care homes, integrated urgent care services, hospitals and other care settings.

There is a need to focus on specialist pharmacist prescribers and advanced practitioners who can improve the care of patients whilst also mitigating any short fall in medical trainees versus rising demand, e.g. oncology reviewing and prescribing chemotherapy, rheumatology etc.

The NHS also needs to recognise and support healthcare professionals who undertake portfolio working and ensure that the system enables and facilitates this way of working. Training and development opportunities must be available to pharmacists wishing to work part time or across multiple settings.

The NHS needs to ensure that we have pro-active rather than reactive models and the better use of technology could enable time savings which can then be allocated to provide more of a focus on care.

There needs to be integrated multidisciplinary workforce education, training and development.

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

In order to support staff we need to ensure better workforce modelling and an understanding of the skills gap. However, just taking a skills based approach and training professionals for specific roles will not work, we need to attract people into traditional generalist roles as well.

Pharmacists are increasingly becoming central to the provision of pharmaceutical care through new roles in general practice, hospital emergency departments and increasing responsibilities within the community. This is recognised in NHS England's current strategy, Five Year Forward View (2014).

The Royal Pharmaceutical Society's (RPS) Careers Task and Finish Group has identified the fundamental role of education and training in the early years' development of a competent, capable and flexible pharmacy workforce. This is particularly relevant in a context of increasingly complex pharmaceutical science, growing patient need and expectation and the prerequisite to improve quality of care. Improving patient care in relation to medicines and medication safety is a priority for the pharmacy workforce in all four nations of the United Kingdom. To deliver the NHS and RPS aspirations for the pharmacy workforce in the future there will need to be an increased investment in post-registration training and development. This must be planned for by HEE to ensure funding is available to make this happen.

The RPS Careers Task and Finish Group was established in 2017 and made recommendations to the Chief Pharmaceutical Officers of all four nations concerning the development and implementation of a UK-wide pharmacy Foundation Programme, and that every newly registered pharmacist should be required to undertake such a Programme. The Foundation Programme will be core to developing a workforce responsive to patient needs and changes in the delivery of healthcare;

To take these recommendations forward, an Education Governance Oversight Board which includes the Chief Pharmaceutical Officers, RPS, NHS education and training structures, universities, employers and the General Pharmaceutical Council has been established to ensure quality control and quality assurance.

There also needs to be a greater focus and delivery on health and wellbeing of staff as well as a recognition and reward for excellence.

3.3 What more could the NHS do to boost staff health and well-being and demonstrate how employers can help create a healthier country?
Improve response to errors using critical industry models such as the aviation industry and focus on work / life balance and flexible working patterns.

Pharmacists, like many other healthcare professionals are experiencing work related stress and they need to be supported in terms of their health and wellbeing. The RPS as the professional leadership body for pharmacists has a role to play in this as do the employing organisations.

The NHS Health and Wellbeing Framework which sets out the standards for what NHS organisations need to do to support staff to feel well, healthy and happy at work, needs to be implemented consistently across all NHS organisations. It should also be utilised by organisations that are providing services to the NHS, such as community pharmacies.

GPs are supported by a nationally commissioned 'GP Health Service' and such services should also be commissioned and delivered nationally for other healthcare professionals such as pharmacists.

All NHS staff, including those employed by providers such as community pharmacies, should have access to occupational health to support their health and wellbeing.

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?

Self-care, supported self-management and person centred care is an important priority for the NHS going forward and IT can support and enable this e.g. the NHS App and App library. Within self-management medicines support is especially amenable to facilitation by IT such as repeat prescription ordering, medicines effects or side effects monitoring, adherence monitoring and support. Systems need to do what patients want or need them to do and not what suppliers can provide or what policy makers think people want. This will ensure that patients are motivated to use them.

Community pharmacists should be used as the first port of call for minor illness. A Digital Minor Illness Referral Service (DMIRS) is being implemented in the North East of England and will be spread across another 3 areas before the end of this year. This service enables NHS 111 to refer patients with minor illnesses - such as sore throats, coughs, colds, tummy troubles, teething, and aches and pains - to a local community pharmacy. In the North East this is also now being expanded to include referrals from GP practices.[10]

Pharmacists working in GP practices and care homes can be better utilised to undertake polypharmacy reviews and reduce the number of medicines some people take, if appropriate.

The use of virtual clinics that facilitate specialist support to primary care clinicians should be further explored and developed.

In terms of prevention, please see our responses to previous questions such as 1.6

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?

There is a substantial body of evidence that shows when patients move between care providers the risk of miscommunication and unintended changes to medicines remains a significant problem. More than 90% of elderly medical patients will have a change to their medicines during an admission to hospital. It has been reported that between 30% and 70% of patients have either an error or an unintentional change to their medicines when their care is transferred. It is vital that there is accurate clinical handover when patients are discharged from hospital. When community pharmacists are included as part of the referral pathway then they provide a pharmaceutical consultation and counselling post-discharge to ensure changes to a person's medicines are known and acted upon in order to improve medicines safety and efficacy when they return to their home or place of care. Where this has been implemented it has demonstrated that those patients who received a community pharmacist follow-up consultation had statistically significant lower rates of readmissions and shorter hospital stays than those patients without a follow-up consultation[11].

[10] https://www.england.nhs.uk/commissioning/primary-care/pharmacy/digital-minor-illness-referral-service-dmirs/

[11] https://bmjopen.bmj.com/content/6/10/e012532.full?ijkey=IzR9HpzxpbKTdzh&keytype=ref

This needs to be expanded to include practice pharmacists working in GP practices so they also receive the most up to date information on discharge.

Having interoperable IT systems will definitely support the transfer of care and will also enable the advice of pharmacists to be communicated to other healthcare stakeholders, and their valuable professional interventions to be rendered visible to all NHS colleagues.

Aligning contracts across primary and secondary care will also help as then organisations are not all competing for the same funding.

Whilst some integrated education does happen at undergraduate level, this should also be encouraged to happen post-graduation across primary care / multidisciplinary teams.

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?

Primary care is not just about general practice and this needs to be recognised as often the term is used to just refer to GP services. Primary care is about the whole of the workforce delivering care to patients in the primary care setting. In terms of the pharmacy workforce this would include pharmacists working in community pharmacies, in GP practices, in care homes, in integrated urgent care settings and in prisons.

All of the primary care workforce need to be included in the developing primary care networks to ensure that the whole of the workforce is used to the best of their ability to improve care for the population in their locality.

As more pharmacist prescribers complete their training they will be able to independently prescribe, within their competencies, and will be able to work closely with traditional prescribers such as GPs.

Links between research arenas such as academic research for evidence gathering need to be strengthened.

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

The increased focus on social prescribing helps support population health management and community pharmacists need to be engaged in this initiative.

Community pharmacists can provide opportunistic detection of undiagnosed disease as 84% of adults visit a community pharmacy each year, a number of whom will have an undetected long term condition

Better use of digital health and technology can help in supporting population health.

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?

It is imperative that patient records, whichever setting they reside in, are shared and interoperable so that everyone who provides care for a patient can see what has gone before. This will enable more informed and accurate actions to be taken.

Patients should be able to see and contribute to their own records, such as measurements they may take at home, concerns they may have, etc. People may also wish to share access to the information they have from wearable technology. They may need support in understanding the results and acting on them.

Better use of digital health and technology could potentially free up clinicians time which can then be allocated to patient care.

Better use of technology can also improve adverse drug reaction reporting and involve patients more in doing this.

Digital health needs to be part of health literacy for patients and clinicians.

The better use of data collection to increase research will help to build the body of evidence and improve evidence-based decision making.

Technology and digital models can be used to improve medicines adherence where appropriate. Already we are seeing digital alerts to remind people to take their medicines.

Digital sources of information and advice are varied and patients need to be directed to robust sources so they can access reliable and evidence based information.

IT systems, informatics and interoperability have the potential to improve care in the NHS by improvement of continuity of care between services, enabling shared care in multidisciplinary care scenarios or patients with complex needs, improving quality of care and enhancing professional decision–making by ensuring the right information is available to a care professional at the point of consultation and enabling routing of referrals in different directions including social prescribing etc.

3.9 What can the health and care system usefully learn from other industries who use digital technology well?

- How to overcome security issues.
- User friendly interfaces.
- Better integration of systems and ensuring compatibility at all levels.
- Vision in the use of technology which demonstrates how IT can be used to work in a different and better way.
- A culture that supports innovation in technology.

3.10 How do we encourage people to use digital tools and services? (What are the issues and considerations that people may have?)

- Facilitate people to realise the benefits of using digital tools and services.
- Reassurance on secure data and the links to data being used for other purposes i.e. insurance companies.
- Make them easy to use

- Make them accessible to those with any disability.
- Patient facing systems and apps must be accessible, straightforward to use, intuitive and provide functions that people actually want to use.

3.11 How do we ensure we don't widen inequalities through digital services and technology?

Ensure that the system is available in all areas of the country and to all individuals before developing advancements. Make digital health more accessible.
Dealing with the digital divide – one fifth of people in the UK don't have a smartphone or access to the internet (tend to be older, more vulnerable and poorer and have the greatest health needs).
Equity of internet provision between urban and rural areas.

3.11 How can we increase opportunities for patients and carers to collaborate with the NHS to inform research and also encourage and support the use of proven innovations (for example new approaches to providing care, new medical technologies, use of genomics in healthcare and new medicines)?

Service evaluation needs to be built into all service delivery and robust evidence collated and shared. There needs to be more emphasis on how things are measured and evaluated to inform decisions around how much value they actually deliver to patients and the NHS. There needs to be more of a focus on outcomes and health economic value to inform decisions around how best to use NHS resources and to be able to compare interventions to deliver best outcomes for patients and best value for the investment made.

Need to raise awareness of the benefits of research in terms of the wider population and increase the links between academia and clinical practice.

3.12 What transformative actions could we take to enable innovations to be developed and to support their use by staff in the NHS?

- Increase incentives / motivations such as recognition / rewards, local competitions.
- Make research / innovation a mandatory component of NHS job descriptions.

3.13 How can we encourage more people to participate in research in the NHS and do so in a way that reflects the diversity of our population and differing health and care needs?

- Make research such as audit, service evaluations and quality improvement projects, part of a contractual framework.
- Link to RPS Faculty research and evaluation cluster.
- Encourage practice based research and keep it simple.
- Raise awareness of benefits and the need for diversity.

3.14 How can we increase research in topics that have traditionally been under-examined?

- Map the landscape to identify the gaps in the evidence-base.
- Raise awareness of the gaps in the evidence base.
- Strengthen opportunities for research collaborations and partnerships.
- Increase the amount of funding for research.

3.15 What should our priorities be to ensure that we continue to lead the world in genomic medicine?
Strengthen opportunities for research collaboration and partnerships (national and international).

3.16 How can the NHS encourage more people to share their experiences in order to provide an evidence base for checks on whether changes introduced under the long term plan are driving the changes people want and need?
This would need to be explored at a national level. The NHS should work closely with charities and patient groups to develop this.

3.17 How can the NHS improve the way it feeds back to people about how their input is shaping decisions and demonstrate that the NHS is the world's largest learning organisation?

Sandra Gidley FRPharmS
Chair, English Pharmacy Board

About us

The Royal Pharmaceutical Society (RPS) is the professional body for every pharmacist in Great Britain. We are the only body that represents all sectors and specialisms of pharmacy in Great Britain.

The RPS leads and supports the development of the pharmacy profession to deliver excellence of care and service to patients and the public. This includes the advancement of science, practice, education and knowledge in pharmacy and the provision of professional standards and guidance to promote and deliver excellence. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums.

Its functions and services include:

Leadership, representation and advocacy: Ensuring the expertise of the pharmacist is heard by governments, the media and the public.

Professional development, education and support: helping pharmacists deliver excellent care and also to advance their careers through professional advancement, career advice and guidance on good practice.

Professional networking and publications: hosting and facilitating a series of communication channels to enable pharmacists to discuss areas of common interest, develop and learn.

EXAMPLE 1: Community pharmacies support medication monitoring in children and young people with attention deficit/hyperactivity disorder (ADHD)

Children and young people who are prescribed medicines for ADHD and related conditions need regular monitoring of key metrics (height, weight, blood pressure and pulse). For many families, a clinic appointment for physical screening means missing school unnecessarily and a parent missing work.

A Sussex Partnership NHS Foundation Trust led project enabled families to select a community pharmacy to provide the physical monitoring of key metrics with the results available to their clinicians via a secure website.

Community pharmacies were able to offer appointments locally at more convenient times. This meant that increased numbers of patients have engaged with medication monitoring, and received improved quality of care closer to home. It is also estimated that around 40% of the child and adolescent mental health services team resource was released for other activities.
www.health.org.uk/programmes/innovating-improvement/projects/developing-community-pharmacies-support-medication

EXAMPLE 2: Physical health checks in community pharmacies

Patients with a diagnosis for psychotic illness have been receiving physical health checks in community pharmacies through a collaboration between North East London Local Pharmaceutical Committee (NEL LPC), North East London NHS FT and University College London, with support from Public Health London Borough of Barking and Dagenham and the London Mental Health Strategic Clinical Network.

Funded by a Health Foundation Innovation Award, patients known to the Barking and Dagenham Community Recovery Team, were offered physical health checks at a local participating community pharmacy. This included ECG, blood pressure, cholesterol and glucose testing with results available on the same day. Pharmacists spent up to an hour coaching patients and empowering them to self-manage their physical health.

From September 2016 to January 2018, 180 patients were offered health checks with 140 (78%) taking up the offer. Of all attendees 70% had all five cardiometabolic risk factors monitored which is significantly better than standard care in Barking and Dagenham, where only 36% of patients had all five risk factors monitored and higher than the NHS England national averages for inpatient and community settings.

psnc.org.uk/services-commissioning/locally-commissioned-services/service-case-study-community-pharmacies-tackle-inequalities-for-patients-with-psychosis/

EXAMPLE 3 Widening access to pharmacist expertise: Pharmacists in liaison psychiatry teams

In order to overcome the divide between mental and physical health, liaison psychiatry services aim to treat people with psychiatric illness and a comorbidity/physical illness in an acute hospital. Liaison psychiatry teams are fully integrated into acute hospitals and available within working hours and out-of-hours. A liaison psychiatry review should provide clear and concise documented plans in the acute hospital notes at the time of assessment; incorporating a management plan including medicines or therapeutic intervention.

Within Northumberland Tyne and Wear there are five Psychiatric Liaison Teams (PLTs) covering 17 sites. The Sunderland Royal Hospital Liaison Team has a pharmacist as a member of the team. The PLT pharmacist provides a link between disciplines within healthcare settings and provides medical and pharmaceutical advice to nursing staff and patients without requiring direct consultant contact. This reduces medical involvement where possible, focuses resources appropriately and saves money. The PLT pharmacist is also an extra resource to acute trust inpatient pharmacy teams when necessary.

In 2017/18 the PLT pharmacist worked for 96 days, received 149 referrals comprising of 137 individuals, and undertook 362 patient-facing medication reviews. Medication changes were made in 94 individuals with 51 including de-prescribing advice. The psychiatric liaison team and acute trust pharmacists were asked for feedback via survey and 95% of respondents considered the service to be good or excellent.

EXAMPLE 4: Prevention of type 2 diabetes in community pharmacies:
Participating patients underwent an assessment using a validated questionnaire to determine their 10-year risk of developing type 2 diabetes within Boots pharmacies. Patients were given appropriate lifestyle advice or referred to their general practitioner if necessary.

Key findings: In total, 21,302 risk assessments were performed. Nearly one-third (29%) of 3427 risk assessments analysed yielded a result of moderate or high chance of developing the condition. Nearly one-third (29.1%) of assessments yielded a result of a moderate or high chance of developing the condition, with 60.4% being conducted on people considered overweight or obese. Community pharmacies can identify a significant number of patients at risk of developing type 2 diabetes in the next 10 years.
http://onlinelibrary.wiley.com/doi/10.1111/ijpp.12139/full

EXAMPLE 5: Screening in community pharmacy
Green Light Pharmacy has a long-standing collaboration with local third-sector bodies and neighbourhood organisations linked to the local authority's Health and Wellbeing Board. The overall project is funded by the Big Lottery and a key delivery stream is focussed on addressing health inequalities that exist between the local population and the rest of the population (of the borough/city/country).

The current service has been branded as WellFair to link it to other services that are available via social prescribing, including healthy walks and patient-led health talks. During the 1 and a half years that this project has been running, Green Light Pharmacy has screened 695 people. Of this

136 people were eligible and consented to having a fuller health check as a follow-up to the screening, looking at vascular health, mental health, cancer screening, and dental/optical health access. This doesn't exclude people with existing health conditions as it is a useful way of re-engaging people with health and social care services.

Around 90% of those receiving full screening were referred to NHS follow-up to address health issues that were identified, primarily related to vascular health but also mental health.
http://www.westeustonpartnership.co.uk/wellfair/

EXAMPLE 6: Early detection of atrial fibrillation in community pharmacies
This project, led by a team at the Royal Brompton and Harefield NHS Foundation Trust, is looking at how the detection and treatment of atrial fibrillation (AF) can be improved via 'enhanced' medicines use reviews in community pharmacies. Community pharmacists currently provide medicines use reviews to patients and are ideally situated to facilitate the diagnosis of AF.

Ten community pharmacists will carry out detailed medicines reviews for patients with risk factors for developing AF, for example high blood pressure or diabetes and, in patients with existing AF, they will check that they are receiving optimised treatment and are taking anticoagulants. As part of the consultation, the pharmacists will use a portable electrocardiography (ECG) device, called an AliveCor monitor, to detect AF. Patients who are found to have undiagnosed AF, are not appropriately anticoagulated, have poor heart rate control, or have high symptom burden, will be referred to the Arrhythmia Care Team at Harefield Hospital, where they will be reviewed and offered individualised treatment.
http://www.health.org.uk/programmes/innovating-improvement/projects/enhanced-medicines-use-reviews-improve-detection-and

In a different study, pharmacists in six pharmacies in Kent undertook atrial fibrillation screening from October 2014 to January 2015. Of 594 patients screened, nine were identified as at risk of having AF and were referred to their GP. The service also identified 109 patients with undiagnosed hypertension, 176 patients with a Body Mass Index of more than 30, 131 with an Audit-C score of more than 5 and 59 smokers. Pharmacists provided 413 interventions in 326 patients aimed at weight reduction (239), alcohol consumption (123) and smoking cessation (51).
http://www.heartrhythmalliance.org/files/files/afa/for-clinicians/Twigg_2016.pdf

EXAMPLE 7: Pharmacists supporting patients with dementia
Pharmacists are ideally placed to recognise any deterioration or decline in mental health and recognise early signs and symptoms of LTCs such as dementia or cancer. The final package for community pharmacy in 2016/17 and beyond introduces a quality payment system and one of the quality criteria is that 80% of all pharmacy staff working in patient facing roles are trained dementia friends.

The majority of community pharmacists England are now dementia friends and Manchester have recently published a framework to ensure all the community pharmacists in the area are dementia friendly environments
http://psnc.org.uk/bolton-lpc/bolton-ccg-information/dementia-friendly-pharmacy-framework/

EXAMPLE 8: Supporting patients to get the most from their medicines

Aimed at patients aged over 65 years taking four or more medicines:

- High users of NHS resources who may not be getting optimal benefits from medicines
- Poor adherence can lead to worsening of the condition
- Adherence is more problematical with multiple medicines
- Older people are more susceptible to adverse drug reactions.
- 620 patients recruited by 25 pharmacies across Wigan in four months across all socio-demographic areas.

Patients saw benefits from pharmacist interventions which improved their understanding of their medicines and addressed specific issues they were having.

After six months, patients had:

- Significant increase in medicines adherence
- Significant reduction in medical and self-treated falls
- Significant increase in patient quality of life.

Patients reported a general improvement in health. Pharmacy teams picked up on a range of issues, not all medicines related. Patients were more satisfied with the management of their condition, a key NHS objective. Quality of life was improved in small but significant ways, such as advising on the correct length of walking sticks and how medicines could fit in with home and social life.

Based on the findings from the FOMM Service, it is estimated that if the service was delivered from 11,100 pharmacies in England to 954,600 patients then the NHS would see annual benefits of:

- £35.57m in reduced medicines costs and hospital admissions as a result of STOPP / START recommendations
- £33.87m in reduced hospital costs due to reduction in falls that result in fractures.
- 17,200 QALYs
- Benefits as a result of improved medicines adherence, pain, and falls that do not require secondary care treatment have not been quantified

http://www.communitypharmacyfuture.org.uk/

EXAMPLE 9: Supporting patients with asthma

In collaboration with other health professionals, community pharmacists were given extra training to deliver structured asthma reviews including reviewing inhaler technique.13 pharmacists carried out reviews in Leicester city centre on 165 patients with follow-up appointments at 3 and 6 months:

- 42% of patients had not had an asthma review at their GP practice in the last 12 months
- 56% had not had their inhaler technique checked in the last year

Using the validated Asthma Control Test (ACT) the results showed most improvement in those patients who had not had an asthma review from their GP in the last 12 months; showing patients receiving significant clinical and quality of life improvement. It is known that people only take their medicines as prescribed 50% of the time which leads to poor outcomes and wasted resources. The study found considerable improvement in patients' compliance with their medicines, resulting in

better overall asthma control. The study demonstrated a 32% decrease in GP appointments and a 40% reduction in hospital admissions. The authors concluded that to improve patient outcomes and thus decrease hospital admissions, pharmacist asthma reviews should be targeted at patients who have not had a review from the GP recently, capitalising on the accessibility and approachability of the community pharmacist.
http://www.pharmaceutical-journal.com/news-and-analysis/features/make-asthma-simple-for-your-patients/11138140.article

EXAMPLE 10: Digital Minor Illness Referral Service (DMIRS)
This digital minor illness referral project enables NHS 111 to refer patients with minor illnesses - such as sore throats, coughs, colds, tummy troubles, teething, and aches and pains - to a local community pharmacy.

The initial project ran from 4 December 2017 to 31 March 2018 across Durham, Darlington, Tees, Northumberland and Tyne and Wear where the North East Ambulance Service NHS Foundation Trust (NEAS) is the NHS 111 provider. It was extended to 30 September 2018 and is now further extended to 31 March 2019.

Over 8,500 patients in the North East have been referred into the service for advice from a pharmacist and over 80% of patients are 'very satisfied' with the service. Only 11% of those patients seen have been referred to a GP for an urgent in hours appointment. The initiative is being piloted in other areas to help reduce pressure on GP care and A&E departments and deliver better access to care, closer to home, and with a self care emphasis.

Previously, less than 1% of NHS 111 referrals were to a community pharmacy - calls were referred to other primary care locations such as general practices (in and out of hours), walk-in centres or, in some cases, A&E. These appointments can restrict access and reduce the time GPs have to focus on patients with greater clinical need.

https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/dispensing-contractors-information/digital-minor

EXAMPLE 11: Virtual clinics for atrial fibrillation
In Lambeth 47 GP practices were involved in an AF virtual clinic. This involved 2 specialist anticoagulation pharmacists reviewing the all patients within the practice who had been identified as having AF but were not currently anticoagulated. Of the 1,340 patients reviewed across the practices 1,292 were anticoagulated preventing an additional 45 strokes per annum.