ROYAL PHARMACEUTICAL SOCIETY

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Pharmacy: Helping to prevent and support people with Cardiovascular disease

HEART UK
THE CHOLESTEROL CHARITY

The Royal Pharmaceutical Society hosted a roundtable to discuss the potential role that pharmacy teams can play in preventing cardiovascular disease (CVD) and supporting patients with CVD.

The roundtable brought together patient groups, pharmacists with experience of providing cardiovascular disease services, GPs and health service and professional bodies (participants are listed in Section 6). The group was asked to identify how services delivered through pharmacy teams might be improved and developed further, as well as how this development might be enabled and action stimulated.

This briefing paper summarises discussions on the day which explored in detail how pharmacy teams across the NHS and public health could be better utilised to benefit the public and patients.
We invite feedback and welcome ongoing discussion on the ideas contained in this paper.

1 Foreword

Cardiovascular disease (CVD) is the leading cause of premature death globally.

CVD accounts for almost a quarter of all premature deaths in England – 33,800 per year – and is a key driver in health inequalities between rich and poor[1]. CVD is also the single biggest area where the NHS can save lives.

There is a huge opportunity to reduce the risk of a person developing CVD, with a new national ambition to prevent 150,000 strokes, heart attacks and dementia cases over the next 10 years.[2]

Achieving this will require new ways of working to support earlier detection of risk factors (such as atrial fibrillation, high blood pressure and high cholesterol), promote healthier living in local communities, and help people get the most from their medicines.

The pharmacy profession is already helping to meeting this challenge and there are some great examples of innovative practice that are making a difference for people around the country.
But we know there is more to do.

The NHS Long Term Plan sets out cardiovascular disease as a national priority, building new partnerships and investing in support for primary care to deliver better outcomes for patients.

This roundtable report explores how pharmacists, as part of the multidisciplinary team, can play a key role.

I would like to thank everyone involved in their contribution, support and advice in the formation of this report.

Claire Anderson,
Chair, English Pharmacy Board,
Royal Pharmaceutical Society

2 Context

Cardiovascular disease (CVD) causes a quarter of all deaths in the UK with around 150,000 deaths from CVD per year in England[3] . In addition, CVD is a key driver of health inequalities, accounting for a quarter of the life expectancy gap between rich and poor.

The three high risk conditions for CVD; Atrial Fibrillation (AF) high blood pressure and high cholesterol all substantially increase the risk of heart attack, stroke and dementia. Treatment is highly effective at preventing cardiovascular events however late diagnosis and under treatment is common and there is wide variation across the NHS.

There is the potential to significantly impact on patient outcomes if medicines are optimised in patients who are under treated and prevent heart attacks and strokes at scale in a short time frame. Pharmacists and their teams can play a key role in helping to identify patients who are undertreated and to optimise their treatment as well as contributing to community mobilisation by offering a pathway for prevention and early detection of cardiovascular risk factors.

The Primary Care Network Contract (Network Contract Directed Enhanced Service Specification) states that 'Better preventions, diagnosis and management of cardiovascular disease is the biggest single area where the NHS can save lives over the next ten years, through fewer strokes and heart attacks.' It is one of an initial seven areas that Primary Care Networks (PCNs) will focus on. From 2020/21 the PCN Network Contract (Direct Enhanced Services) (DES) will be amended to include collaboration with non-GP providers as a mandatory requirement[4].

The Community Pharmacy Contractual Framework (CPCF) ensures that by 2020 all community pharmacies will be Health Living Pharmacies[5]. The contract also states that a new CVD service will be tested: 'A model for detecting undiagnosed CVD in community pharmacy and referral to treatment within PCNs, complementing the CVD service specification in the new PCN contract'.

3 How can pharmacists have a greater role?

Roundtable discussions identified models in which pharmacy teams are already playing a significant role in both supporting people to stay healthy through prevention and supporting patients with CVD, as well as looking at how more support could be provided or scaled up across the country.

There was felt to be scope for pharmacy teams working within or in collaboration with PCNs to support healthy living and prevention, early detection of cardiovascular disease and treatment of stable chronic illness in primary and community-based settings as part of multidisciplinary teams. Making more specialist medicines optimisation support available in both primary care and in hospitals was also identified as an opportunity.

It became clear that a range of different models of care for people with cardiovascular disease, or to prevent people from getting it, are developing. However these are localised innovations and there is variability across England.

What was less clear was the extent to which these models are being integrated into existing services and there was a general view that as services develop they need to link up existing services and optimise the use of pharmacy expertise. This needs to include the development of co-created services that are integrated to support local populations and have defined direct referral pathways to and from pharmacists providing these services.

The question of how best practice is shared across systems was raised and this is considered in section 4 along with other potential enablers.

The group then considered where pharmacy teams can offer support for cardiovascular disease and highlighted some examples of practice.

3.1 PREVENTION & HEALTHY LIVING

Due to their accessibility and the number of contacts with patients and the public, community pharmacists and their teams have a clear role to play in supporting healthy living and the prevention of CVD. There are already models in place such as **Healthy Living Pharmacies**[6] that can support people to make the lifestyle changes necessary to prevent the development of CVD. By April 2020 every community pharmacy will need to become accredited as a Healthy Living Pharmacy. This is a model in which health champions deliver opportunistic brief interventions around lifestyle advice (and early detection see 4.2) that supports cardiac health and is a key way in which pharmacy teams could do more. Doing more with Healthy Living Pharmacies could be linked to better use of public health campaigns to include cardiovascular disease. Ultimately the Healthy Living Pharmacy model could be used to increase pharmacy activity in public health and prevention across a range of areas.

The role of **NHS Health Checks** as part of the prevention and healthy living agenda was discussed. Currently commissioned by local authorities, the view around the table was that overall the provision of NHS Health Checks is variable and that in order to increase uptake there was an opportunity to better use the multidisciplinary team, increasing access and sharing workload. The NHS Long Term Plan[7], published after the roundtable, acknowledges the need to work with local authorities and Public Health England (PHE) to improve the effectiveness of approaches such as the NHS Health Check to rapidly identify people with high-risk conditions.

The importance of including pharmacy services as part of an approach of sustained community engagement in healthy living and prevention was discussed. This would include links with public health initiatives, personal health budgets, new support for people to manage their own health in partnership with patient groups and the voluntary sector, and social prescribing. Case study 1 highlights how pharmacy services can be incorporated into a collaborative community wide approach to reducing blood pressure.

CASE STUDY 1: PUBLIC HEALTH COLLABORATIVE SUPPORTS BLOOD PRESSURE REDUCTION

The Merseyside Pharmacy Local Professional Network has been working with the Champs Public Health Collaborative to influence the Cheshire and Merseyside CVD strategy. The work has focused on better utilisation of Healthy Living Pharmacies (HLPs) for delivery of the strategy.

In 2017, Saving lives: Reducing the pressure was launched in Cheshire and Merseyside and sets out the vision, aims, objectives and high level action plan for the prevention, detection and management of high blood pressure. The HLPs' role was recognised in all three areas of prevention (Making Every Contact Count), detection (BP and AF screening) and management (medicines optimisation tools, medicines reviews/NMS).

120 HLPs were recruited in a British Heart Foundation (BHF) funded BP screening pilot with a further 120 due to be recruited in 2019. In two areas another project is being developed to link HLPs with GP pharmacists to also detect and manage new AF patients. The HLPs were automatically included in the Blood Pressure UK's 2017 Know Your Numbers!® Week that aimed to help increase detection of the estimated 260,000 people in Cheshire and Merseyside who have high blood pressure but don't know it.

In addition a new BP service funded by local NHS and CCGs is being offered as an expansion for the HLPs in the BHF pilot once they have reached their minimum screening quota that, in addition to screening, offers medicines optimisation opportunities to existing hypertensive patients.

The Champs Public Health Collaborative (www.champspublichealth.com) delivers local priorities agreed in partnership with Public Health England North West and NHS England Cheshire and Merseyside.

Further reading

Saving Lives: Reducing the Pressure Annual Report 2018 www.champspublichealth.com/saving-lives-reducing-pressure-annual-report-2018

3.2 EARLY DETECTION

Early detection and treatment of CVD can help people live longer, healthier lives. Many people are still living with undetected, high-risk conditions such as atrial fibrillation (up to 500, 000 people)[8] , high blood pressure (one in 10 people[9]) and raised cholesterol. Community pharmacists and their teams, and pharmacists in PCNs can, and in some parts of the country already do, provide opportunities for the early detection, case-finding, and treatment of these high-risk conditions.

Early detection of atrial fibrillation by community pharmacy teams and PCN pharmacists was highlighted as a key area where care and patient outcomes could be improved. Strokes related to atrial fibrillation have worse patient outcomes[10] . It is clear from discussions at the roundtable that this is an area across England where different service models are being developed and piloted often with specialist input from secondary care hospital pharmacy teams.

The importance of developing a sustainable model as part of a PCN with defined referral pathways that include pharmacy services was stressed (see case study 2). This is now being considered as part of the Community Pharmacy Contractual Framework and a fundamental part of the PCN CVD prevention and diagnosis network enhanced service.

As well as opportunistic interventions (see case study box 3), the need for a strategic approach to case finding was also highlighted (see case study boxes 4 and 5).

Atrial fibrillation has been a part of the innovations programme for the Academic Health Science Networks (AHSNs) and there have been a range of initiatives across the networks to improve early detection as well as treatment of atrial fibrillation. Many of these initiatives have looked at how community pharmacists can play a role.

CASE STUDY 2: PUBLIC HEALTH COLLABORATIVE SUPPORTS BLOOD PRESSURE REDUCTION

Surrey Heartlands Health and Care Partnership is a developing Integrated Care System (ICS) with a devolution agreement between Surrey Heartlands, NHS England and NHS Improvement.

One of the key priorities identified by the ICS was prevention and planned care, with a strong focus on Cardiovascular disease. In Surrey Heartlands coronary heart disease and cerebrovascular disease are the second and third largest contributors respectively to premature mortality. Two thirds of deaths could be avoided through improved prevention, earlier detection of factors such as hypertension and diabetes and improved treatment in primary care.

Throughout 2018 work began to develop and operate under one Surrey Heartlands cardiovascular operating model, to deliver a cardiology service across the region.

Committed to the Surrey Heartlands citizen-led co-design communications and engagement initiative, discussions involved clinicians GPs, consultants, community pharmacists and specialist nurses as well as members of the public to understand the population needs; investigate optimal pathways and agree a collaboratively developed work programme.

Working with the Kent, Surrey and Sussex Academic Health Science Network the programme will distribute over 100 mobile ECG devices to a range of settings including community pharmacies, GP practices, community nurses, patients' homes and community hospitals. These units can be used to carry out opportunistic pulse rhythm checks and identify people who have atrial fibrillation (AF) so that appropriate care can be provided. The devices have been shown to be an effective, low-cost solution for identifying new AF and reducing the risk of AF-related strokes.

A key theme of the citizen-led co-design was the role community pharmacy could play in the prevention and wellbeing agenda, which has led to Surrey Heartlands ICS partnering with Community Pharmacy Surrey and Sussex (the Local Pharmaceutical Committee (LPC)) to develop the community pharmacy element, offering blood pressure and atrial fibrillation (AF) checks alongside healthcare advice to manage these conditions. The service is to be developed by the LPC service development and support pharmacist, funded by Surrey Heartlands ICS. The service is expected to be launched later in 2019.

CASE STUDY 3: **EARLY DETECTION OF ATRIAL FIBRILLATION THROUGH COMMUNITY PHARMACIES**

Capture AF Service

Objectives of the service are; to improve the detection and treatment of undiagnosed atrial fibrillation, to improve anticoagulation prescribing for inpatients with diagnosed AF, to:

1. facilitate early referral to a specialist centre
2. improve adherence to anticoagulation using the New Medicines Service.

Thirty community pharmacists from the Hillingdon area were recruited and trained; ten in 2016 for the pilot study and a further twenty when the project was scaled up in 2018/19. Patients were selected by community pharmacists as eligible (≥65 year old with AF associated risk factors) for a specially designed AF medicines review. A handheld Kardia ECG (NICE approved technology) was used to detect AF. Patients are referred directly to the Arrhythmia Care Team (ACT) at the Royal Brompton and Harefield Hospital. Once diagnosis is confirmed anticoagulation is started and the patient is referred to their community pharmacist for the New Medicines Service to help support adherence.

www.youtube.com/watch?v=_9JKlHWQWY4

The need for a strategic approach to case finding was also highlighted as an important part of early detection and treatment (see 3.3 below).

"Where 100 people with AF are identified and receive anticoagulation medication, an average of four strokes are averted, preventing serious disability or even death."
NHS Long Term Plan

3.3 PRIMARY CARE NETWORK MANAGEMENT OF CARDIOVASCULAR DISEASE BY PHARMACISTS

Case finding and better management of cardiovascular care in primary care was identified as an area where pockets of innovation exist. Examples the group heard about included GP practice pharmacists increasingly managing cardiovascular patients (see case study box 4).

We would expect that community pharmacy is included in the formation of the national service specification for CVD as they can play a significant role in ensuring delivery.

As well as pharmacists working in general practice, the group heard about virtual clinics running in primary care that are accessing the medicines expertise of specialist or consultant cardiovascular pharmacists based in hospitals to provide both direct patient care in primary care and as a teaching model for primary care (see case study box 5).

CASE STUDY 4: PHARMACIST LED CVD CLINIC IN GENERAL PRACTICE

Pharmacist led CVD clinic in general practice

Churchdown Surgery in Gloucestershire (14,000 patients) developed a new cardiovascular pathway in 2016. The aim of the new pathway was to improve patient experience and cardiovascular outcomes whilst easing the burden on GP appointments for initiation or titration of blood pressure medications/ statins and medication reviews.

Nurse-led hypertension and CVD monitoring clinics did not have sufficient capacity with the nursing team, GP reviews were opportunistic and the practice had to put on extra clinics at end of year to meet quality and outcome framework targets. The full-time appointment of a GP practice pharmacist with an independent prescribing qualification presented an opportunity to introduce a more robust system of monitoring.

The new pathway utilises the skills of the pharmacist and healthcare assistants and includes the annual recall of patients with known hypertension and cardiovascular disease, in addition to patients presenting with a newly raised blood pressure. The clinic includes all patients currently on the hypertension, coronary heart disease, peripheral arterial disease (PAD), or stroke/TIA registers. As an independent prescriber, the pharmacist can diagnose and manage hypertension and can start/ amend/stop medications for other conditions if needed. The pharmacist also undertakes frailty/ polypharmacy reviews and routine medication reviews at the same time, saving repeat appointments for the patient.

The pharmacist-led pathway has led to lower average blood pressures and an increase in the proportion of patients taking statins which will reduce the risk of cardiovascular events over the next 10 years. The patient satisfaction questionnaire results show satisfaction in the care provided by the pharmacist. This pathway was one of a number of changes the practice made which meant the GPs could extend their appointment times from 10 to 15 minutes.

CASE STUDY 5:

VIRTUAL ANTICOAGULATION CLINICS WITH SPECIALIST PHARMACISTS

A 'virtual clinic' approach targeting AF patients on GP registers who were not receiving anticoagulation, initially led by Lambeth and Southwark CCGs and King's College Hospital, is now being rolled out by a number of Academic Health Science Networks and across 23 CCGs between December 2018 – March 2020.

In this model, specialist anticoagulation pharmacists systematically searched GP records to case-find patients who had been diagnosed with AF, but were not receiving optimal management and treatment. Patients who were not being optimally managwed were then discussed in a 'virtual clinic' between the specialist anticoagulation pharmacist and a GP, to recommend an optimal course of treatment. The 'virtual clinics' are so-called, as they can be carried out remotely, via telephone, Skype or videoconference. Following the virtual clinic, the GP meets with the patient to discuss and agree on a course of treatment.

The pilot in Lambeth and Southwark was carried out between October 2015 – December 2016, and reviewed the 1,340 patients and anticoagulated an additional 1,292 patients. It is estimated that this pilot prevented approximately 65 strokes per annum across the two CCGs.

www.londonscn.nhs.uk/wp-content/uploads/2017/07/nhs-lambeth-virtual-clinics.pdf

It has been estimated that scaling up this local pharmacist-led model across England, could prevent an estimated 3,000 AF-related strokes and save 750 lives.

www.ahsnnetwork.com/about-academic-health-science-networks/national-programmes-priorities/atrial-fibrillation

Care home residents are increasingly seeing the care they are offered through the NHS improved in line with the Enhanced Health in Care Homes model developed through the NHS England vanguards programme. This includes regular pharmacist-led medicine reviews where needed and provides the opportunity to optimise cardiovascular medicines in frail and elderly people[12]. Building on NHS England's Medicines Optimisation in Care Homes Programme, Primary Care Networks must enable care homes to be supported by a multi-disciplinary team of healthcare professionals including pharmacists and pharmacy technicians.

More than 16 million people in England are diagnosed with a long-term physical health condition, and one in three of this group will experience a mental health problem. Pharmacists and their teams need to be aware that the diagnosis of a long term condition such as cardiovascular disease is a trigger point for the development of a mental health problem. Signposting people to help and support for a mental health issue needs to be a generalist skill for all pharmacists[13]. Pharmacy team members can train as mental health champions to support mental wellbeing in people with CVD.

3.4 ACUTE HOSPITAL BASED CARE

In the hospital setting specialist pharmacists are key members of the multidisciplinary team and have a pivotal role to play in supporting people with cardiovascular disease. The group heard about pharmacists working as members of an inpatient heart failure team with a focus on identifying people admitted with undiagnosed heart failure across the trust and initiation of treatment (see case study 6).

We also heard about pharmacists running pre-operative surgery clinics to ensure medicines were optimised, medicines optimisation outpatient clinics focused on up titrating medicines, and reviewing and/or changing medicines.

Hospital pharmacists have an ideal opportunity to support people with lifestyle and health promotion advice (e.g. smoking cessation, increasing physical activity, reducing alcohol intake) when patients are admitted to hospital, especially those with a new diagnosis of CVD. They can also signpost to local services and social care link workers whether based in community pharmacies or through other community providers such as third sector organisations.

Specialist and consultant pharmacists in CVD also have a key leadership role to play in supporting medicines and the development of pharmacists (and other healthcare professionals) across primary and secondary care, especially as care shifts towards being delivered more in community settings as part of ICSs. However, there was an acknowledgement that there is a shortage of consultant pharmacists and specialist pharmacists with the skills necessary to train colleagues and support this shift (see enablers section 4)[14].

With key drivers such as the Get It Right First Time (GIRFT) programme, we would expect pharmacists in hospitals to have a key role to play in helping reduce unwarranted variations across all speciality areas including cardiology and place a vital role as part of hospital specialist multidisciplinary teams.

CASE STUDY 6: HEART FAILURE PHARMACIST

City Hospitals Sunderland incorporates the specialist pharmacist into the multi-disciplinary team. The Heart Failure Pharmacist is a permanent member of the Inpatient Heart Failure Team which consists of a consultant cardiologist, a geriatrician and a heart failure nurse.

The objectives for the heart failure service are to comply with the national heart failure audit, to achieve NICE quality standards, co-ordinate care between cardiology and other specialities, improve outcomes for patients and to provide effective management for patients transferring to primary care.

The heart failure pharmacist's inpatient role includes identification of heart failure patients regardless of the reason for admission, as well as initiating and monitoring treatment, referral, medication review and ensuring follow up on discharge. The outpatient role includes diagnosis, monitoring stability after discharge, up titration of medicines and communication with primary care colleagues.

Overall the service provides patients with early and continued input from a dedicated multidisciplinary Heart Failure team, aids in the up titration of medicines during hospital admission and after discharge, provides patient counselling and lifestyle advice, provides early follow up after discharge (within 2 weeks) and offers specialist heart failure advice to other health care professionals.

Having a pharmacist as a core member of the team provides an additional area of expertise around medicines that is of particular use in people with complex multiple conditions, taking a large number of medicines and/or with ageing pharmacokinetics.

3.5 INTEGRATED PATHWAYS ACROSS SECTORS

The group discussed where services might develop in the future. It was felt that as care moves out of hospital that there was a need to develop medicines optimisation services in primary care settings that meet all the needs of patients. Ideally this will be facilitated by a systems approach to medicines optimisation across ICSs and PCNs. Each ICS will be responsible for developing services that fit their local population needs so approaches will differ. However, as services develop, there needs to be integration of pharmacy teams into referral pathways in a way which promotes cross-boundary working, delivered through a mix of local and national commissioning by the NHS and local government.

Defined discharge pathways from secondary care are needed to ensure medicines optimisation in primary care after cardiovascular events. For example, for people coming home after a myocardial infarction there is a need to up titrate doses of ACE inhibitors and beta blockers as this is often not possible prior to discharge.

Equally when some cardiovascular patients leave hospital they require additional support taking their prescribed medicines. This may be because their medicines have changed or they need help taking their medicines safely and effectively. Pathways may vary from locality to locality, but where services such as the community pharmacy New Medicines Service exist these can be utilised. There is also a need to join these up with social care pathways and pharmacists and their teams can play a role in supporting social care teams[15].

4 How can change happen?

There was enthusiasm around the table for pharmacists and their teams to become more integrated into patient pathways so that they are able to provide support to help with the prevention, early detection and treatment of people with CVD.

However, it was acknowledged that for pharmacists to become trusted members of teams that work across settings will require concerted effort both locally and nationally. The group discussed how the profession might work together with other stakeholders to enable change to happen.

4.1 WORKFORCE, TRAINING AND LEADERSHIP

The training and education of pharmacists needs to develop pharmacists with the skills necessary to support the clinical management of cardiovascular disease as well as other chronic and acute conditions. This is from undergraduate level onwards to ensure that pharmacists are able to apply their training in practice to maintain and develop their competencies and confidence as part of a multidisciplinary team. Areas highlighted where undergraduate training needs more focus included, diagnosis, physical assessment, person centred consultation, public health interventions, more complex medicines review and in emerging new therapies.

The management of cardiovascular disease across the system will require pharmacists with different levels of training, knowledge and skills depending on the complexity of patients' conditions. This might range from support for early detection and prevention, through to primary care management of hypertension or atrial fibrillation, up to specialist in-patient management of acute heart failure.

A standardised approach to the post-registration training of pharmacists with clarity about the skills and competencies needed to provide cardiovascular services at different levels across the health service is needed. This will provide other healthcare professionals, commissioners and patients with confidence in the skills that pharmacists have. The implementation of clear development pathways for pharmacists from early years training through to advanced practice and consultant level will also enable the development of more consultant and specialist cardiovascular pharmacists.

In undergraduate and early years practice, enabling pharmacists to develop experience across sectors will promote understanding of the role of other professions, improve collaboration and integration, and increase the agility of the pharmacy workforce. Pharmacists can increasingly be part of rotational workforce models that utilise the workforce better to manage larger patient populations and deliver innovation.

Further development of pharmacist independent prescribers is another key enabler that will allow competent pharmacists to provide cardiovascular services. As pharmacists become prescribers the roles that allow them to use these skills will need to evolve. Potentially isolated practitioners with limited access to professional networks may also need structured support.

4.2 DIGITAL AND TECHNOLOGY

Data is an enabler of targeted services that support people with cardiovascular disease. The interrogation of data sets across populations to target interventions for high-risk patients is already happening, for example, in conditions such as cardiovascular disease and diabetes, and to improve patient safety with high risk medicines.

Pharmacists are already increasing the efficiency of data interrogation to target patients most likely to benefit from interventions, typically as part of general practice teams or on a wider locality footprint, as well as in hospital settings. As data is collected, algorithms can better identify patients that need to be seen.

Technology can also be used to link pharmacists delivering medicines optimisation services with other parts of the system. In general practice, pharmacists managing patients outside the surgery have remote read-write access to patients' notes (with the patient's permission). E-referral to improve transfer of care, for example, community pharmacy referral on discharge from hospital for a new medicines service review, is being tested through the AHSNs.[16]

Community pharmacies are increasing their digital maturity. Pharmacists now have read-only access to the summary care records[17] to support the management of patients with cardiovascular disease. Widening this to allow updating of a clinical record was considered to be an important enabler to service development and patient safety.

These developments in enabling technology will continue and pharmacists need to embrace the opportunities that technology offers to develop services and importantly to code activity and develop the evidence base that supports extending the role of pharmacists (see 4.4 Research and Innovation). Supporting teams with potential technology solutions, training and governance will further support service development.

Technology can also be used by patients to help them to support their own health. Mobile health apps are now widely available, and support patient self-care, prevention and early detection of particular health conditions. Through the NHS Long Term Plan, the NHS is supporting the development of apps and online resources to support a variety of health conditions, including CVD.

4.3 PRIMARY CARE

There is an opportunity through emerging PCNs, ICSs and the aspirations of the NHS Long Term Plan to take a strategic approach to population health and in particular CVD, linking up priorities across a population and reducing unwarranted variation.

The NHS Long Term Plan clearly identifies CVD as a priority for the next ten years. Over this period, PCNs and ICSs will be a vehicle for joining up cardiovascular care across sectors. Multidisciplinary teams including pharmacists will be central to delivering integrated services. The new PCN Network contract has reinforced the emphasis on secondary prevention of cardiovascular disease with the clear expectation that increased numbers of PCN pharmacists will play a key role in supporting more integrated working across the PCNs as they mature.[18] This is supported by the new CPCF.

GP practices that sign up to the new Primary Care 'Network Contract' will receive funding for additional clinical pharmacists, who will need to be either enrolled in or have qualified from an accredited training pathway, so they are equipped to fulfil the responsibilities of the role.[19]

The group recognised that primary care is broader than general practice, and community pharmacy plays a crucial part in improving patient care and safety around CVD. With PCNs maturing over the coming months, there is an opportunity for community pharmacy to partner and collaborate with them to help deliver local population health approaches to long term condition management.

In addition, Public Health England and NHS England have recently agreed ambitions which seek to address the A (atrial fibrillation), B (blood pressure) and C (cholesterol) of secondary prevention and reduce the health inequalities associated with CVD over the next 10 years . Pharmacists and their teams are embedded as part of the delivery of this national ambition.[20]

4.4 RESEARCH AND INNOVATION

The increasing numbers of pharmacists across PCNs , along with mental health, community and hospital pharmacists are in a position to contribute to research/service evaluation and bring innovation into wider practice. The profession as a whole needs the skills to be research ready to support the spread of innovation. Consultant cardiovascular pharmacists have a leadership role that includes the support of research and innovation and can enable and support across the system.

Ensuring time and support within roles and services for research and evaluation is a challenge. Pharmacists need more support in conducting research and data collection collaboratively and on a bigger scale, rather than in their individual practices or pharmacies. Collaborations with AHSNs and academic colleagues will support this agenda. Undergraduate and post graduate training in research skills, supporting and leading research is important.

Publication of service evaluations and promotion through conferences and networks will support the scaling up and spread of innovation.

A key mechanism to support research and innovation is the use of data and coding of clinical activity and linking pharmacist activity to other patient data sets. This is a new skill for the majority of pharmacists and an area where support may be required (see also digital and technology 4.2).

4.5 CLINICAL REVIEW OF STANDARDS

Professional standards for services can support the development of person centred care by helping providers to deliver safer, consistent and more effective services. They also promote a common understanding about what pharmacy services provide. Standards will help to drive the quality of services across England and in local commissioning help reduce variation of CVD service provision.

The updated Quality and Outcomes Framework for general practice will increase the focus on quality improvement and encourage further progress in tackling CVD.[21] The focus on quality improvement is increasing and will need to be at the heart of services delivered through pharmacists and their teams. Training in quality improvement techniques will enable pharmacists to develop these skills.

RPS develops professional standards, such as for hospital pharmacy services,[22] which can support quality improvement, as can cardiovascular quality standards published by the National Institute for Health and Care Excellence.[23]

With the increased importance of a multidisciplinary approach to prevention and detection of cardiovascular disease, existing multi-professional standards can also be utilised for quality improvement as well as feeding into continuing professional development.

4.6 SYSTEMS ARCHITECTURE

With the NHS Long Term Plan, systems architecture is changing, especially in primary care with the formation of PCNs. Pharmacy needs to find its voice and engage with emerging local structures and the commissioning landscape. National leadership can facilitate but it is local leadership that can open doors to the development of local systems of care.

For CVD, pharmacists can provide expert advice and clinical perspective on leadership groups, for example, pharmacist involvement with PHE'S local partnerships with NHS Right Care and the PHE CVD system leadership forum. Leadership training and development for pharmacists will support engagement.

The development of a system-wide approach to the delivery of medicines optimisation is being tested and developed through the NHS England Pharmacy Integration programme as part of the NHS Pharmacy and Medicines Optimisation leadership pilots across seven ICS/STP areas[24]. Governance and accountability for achieving health outcomes across populations requires pharmacy leadership at all levels supported by the Regional Medicines Optimisation Committees.

4.7 ENGAGEMENT AND LEADERSHIP

Public engagement remains a challenge, given the variation in local services available and the ongoing changes to NHS structures. Supported by NHS England's Help Us Help You campaign, the narrative around pharmacists' clinical role is changing with the public and patients however. There is still work to do to ensure that people understand the role of pharmacy and the services offered. We need to ensure that we continue to develop the narrative with patients and the public.

Engagement with patients and the public should run through the development of any service. Co-production with patients and the public that involves engagement as services are conceived and designed, right through to feedback, and subsequent involvement in quality improvement.

As well as changing the narrative with patients and the public, work needs to continue with articulating and demonstrating to other healthcare professionals the importance of being able to draw on pharmacists' skills and expertise, and how that supports better decision-making and good patient care.

Visible local pharmacy leadership is an essential enabler across the system and in primary care as the new system architecture develops, such as PCNs and ICSs. Primary care remains in many areas GP-led and the challenges in developing pharmacy leaders are similar to those faced by other health professionals, such as the allied health professions and nurses. As previously highlighted, there is significant variation in the availability of consultant cardiovascular pharmacists, but if services are to move out of hospitals and into primary care the skills and leadership of consultant pharmacists will be crucial.

5 Conclusions

Momentum continues to build around the role that pharmacists and their teams can play as part of a multidisciplinary team across PCNs and the emerging ICSs in England for the prevention, early detection and management of CVD.

It was clear from discussions that local systems leadership is a key enabler and that pharmacists must engage locally with this agenda. As STPs develop their plans and move towards ICSs, PCNs will play an important role with pharmacists locally contributing to planning as part of a community multidisciplinary team. The sharing of solutions and existing models of care will inform service developments. Locally consultant cardiovascular pharmacists can contribute to developing a system wide approach that engages pharmacy teams from across the system.

Workforce was a clear theme in discussions. To enable the development of services, there is a need to better define post registration education pathways and progression generally, and for cardiovascular services specifically. The development of the future workforce needs to start at undergraduate level. Building on the work of the NHS England Pharmacy Integration Fund schemes, up-skilling the existing workforce to deliver clinical patient facing services as part of a multidisciplinary team, along with underpinning skills in public health, research and innovation, and systems leadership is something that pharmacy bodies and NHS organisations need to enable and encourage collaboratively.

6 Roundtable participants

Caroline Barraclough	Regional Manager, East Midlands	Centre for Pharmacy Postgraduate
Janine Beezer	Advanced Clinical Pharmacist, Inpatient Heart Failure Team	City Hospitals Sunderland
Alastair Buxton	Director of NHS Services	Pharmaceutical Services Negotiating Committee
Terry Dowling	Principal Pharmacist, Haemostasis & Thrombosis	Guy's & St. Thomas' NHS Foundation Trust
Richard Fitzgerald	Patient Advocate	Cardiovascular Care Partnership (UK)
Gail Fleming	Director of Education	Royal Pharmaceutical Society
Sandra Gidley	English Pharmacy Board	Royal Pharmaceutical Society
Jenny Hargrave	Director of Innovation in Health & Wellbeing	British Heart Foundation
Malcolm Harrison	Chief Executive	Company Chemists' Association
Anne Joshua	Head of Pharmacy Integration	NHS England
Dr Matt Kearney	National Clinical Director for Cardiovascular Disease Prevention	NHS England
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