ROYAL PHARMACEUTICAL SOCIETY

Health and Social Care Committee Expert Panel
Evaluation of pharmacy services in England

1. The Royal Pharmaceutical Society is the professional body for pharmacists in Great Britain, representing pharmacists working in all sectors. This response has been informed by feedback from members of our English Pharmacy Board and Expert Advisory Groups[1], including on community pharmacy, primary care, hospital pharmacy and digital.

Community Pharmacy: Pharmacy Access Scheme

"Maintain a Pharmacy Access Scheme (PhAS) within the Community Pharmacy Commitment Framework (CPCF) to continue to protect access to local physical NHS pharmaceutical services, in areas where there are fewer pharmacies. Update and improve the PhAS."

2. The Government has met it commitment to provide a Pharmacy Access Scheme but has failed to improve it sufficiently. As of January 2022, 1,445 pharmacies are eligible for additional payments under the scheme. In general, the public have good access to pharmaceutical services. An estimated 80% of the population are less than a 20-minute walk from a community pharmacy[2], which rises to 99.8% in the most deprived areas.[3]

3. While the PhAS requires community pharmacies to register to provide Community Pharmacist Consultation Service in order to receive access payment, which helps to promote provision of the CPCS service, there has been little update and improvement of the PhAS to maximise its effectiveness in protecting access to pharmacies.

4. The management and location of pharmacies continues to face challenges, primarily related to funding. At present pharmacies are closing due to financial pressures which are prevalent across the community pharmacy sector, and this is impacting on the access to pharmaceutical services.

5. Adjusting for inflation, the value of the NHS pharmacy contract in England has shrunk by 25% since 2015; accounting for a lower percentage of total health spending than at any point since 1948. Pharmacies of all sizes are at the risk of closing due to the impact of high inflation and reduced funding, amongst other factors.[4] Since 2015, 670 pharmacies have permanently closed and 41% of those closures have taken place in the 20% most deprived parts of England.[5] While this scheme may have helped in some areas, there has been further deterioration in access to services in others.

6. An earlier review of the scheme concluded that while there had been fewer pharmacy closures of PhAS-supported pharmacies, this came at a cost to all other community pharmacy contractors. We are concerned that, considering the current financial restrictions, the scheme may no longer be fit for purpose. We would welcome the Government investing in a coordinated and structured review of this scheme in the context of a new contractual framework.

[1] https://www.rpharms.com/about-us/who-we-are/expert-advisors
[2] https://questions-statements.parliament.uk/written-questions/detail/2022-12-01/101077
[3] https://questions-statements.parliament.uk/written-questions/detail/2022-07-20/40982
[4] https://www.npa.co.uk/wp-content/uploads/2022/09/Protecting-UK-Public-Interests-in-NHS-Community-Pharmacy-September-2022.pdf
[5] https://thecca.org.uk/40-of-pharmacy-closures-in-last-seven-years-have-occurred-in-deprived-communities/

Community Pharmacy: Funding Model, Dispensing and Services

"Review the funding model *and the balance between spend on dispensing and new services within the CPCF as part of creating the capacity and funding necessary to deliver the wider shift towards a greater emphasis on service delivery."*

7. While some new services have been introduced, the Government has not yet met its commitment in this area. There has not been a sufficient shift in the emphasis on service delivery and the Community Pharmacy Contractual Framework (CPCF) remains focussed on dispensing and the supply of medications. Around 2.9% of the national funding for the CPCF is spent on clinical services (2021/22). This is expected to grow to 4.4% (2022/23) and then over 6% (2023/24). This contrasts with the 2021 pharmacy contract in Wales, for example, which set out to accelerate the redistribution of funding to support aspirations for the wider availability of clinical services from all pharmacies.[6]

8. The pharmacy profession is vital to supporting the safe and effective supply of medicines, while also ensuring that patients are supported to get the best possible outcomes from their medicines. Community pharmacy has a key role to play in improving the public's health as it is a point of contact for those who are generally in good health but could benefit from a better understanding of elements that could cause ill health in the future. We believe the contractual framework could go further to realise this purpose.

9. There must be a radical shift in the contractual framework so that the majority of funding is based on direct patient care instead of medicines supply. While there were welcome steps outlined in the *Delivery plan for recovering access to primary care* (also known as the Primary Care Recovery Plan), there needs to be a renewed commitment from the Government and NHS for an enhanced clinical role for community pharmacists. They should explore the opportunity for pharmacists to be paid on patient outcomes. Some pharmacy contractors have chosen not to expand services (e.g. contraceptive services) due to the perverse incentives within the contractual framework.[7] The community pharmacy network provides patient with immediate access to the NHS, which must be backed by adequate support. A Taskforce for Lung Health survey of people with lung disease found that 86% of respondents felt there were more services that community pharmacies could offer.[8]

10. Services offered by community pharmacies are inconsistent across the country, creating postcode lottery. While a 'Pharmacy First' service from community pharmacies in England is a positive step and will support a more consistent service for the public this announcement was made outside of the CPCF as part of the *Delivery plan for recovering access to primary care* (the Primary Care Recovery Plan)[9] and fails to address the underlying challenges faced in the CPCF itself.

11. Currently the contracts across the different primary care providers, especially general practice and community pharmacy, promote competition rather than collaboration between professionals and this impacts on service delivery for the local population. With the delegation of commissioning to ICBs, NHS England has a responsibility to review primary care contracts and ensure that they are aligned to support truly integrated working at a system level.

[6] https://www.gov.wales/sites/default/files/publications/2021-12/a-new-prescription-the-future-of-community-pharmacy-in-wales.pdf
[7] https://www.chemistanddruggist.co.uk/CD136973/Day-Lewis-halts-pharmacy-contraception-service-until-funding-progress-made?utm_source=sfmc&utm_medium=email&utm_campaign=2023_02_28_CDDaily
[8] https://psnc.org.uk/our-news/pharmacy-services-a-lifeline-for-people-with-lung-conditions/
[9] https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/

12. Community pharmacies have a significant role to play in terms of the delivery of public health services.[10] They deliver a range of public health services through the Healthy Living Pharmacy (HLP) framework[11], including substance misuse management, smoking cessation, alcohol intervention, weight management, contraception and emergency hormonal contraception, and vaccination services. We know that patients are comfortable and happy with the service provided by Healthy Living Pharmacies and these services reduce the need for GP appointments. The community pharmacy network requires further investment in the commissioning of public health services from pharmacies. The announcement to deliver oral contraception and the detection of high blood pressure services from community pharmacies as part of the Primary Care Recovery Plan is welcome.[12]

13. From 2026, all newly-qualified pharmacists will join the register as independent prescribers. It will be vital for the Government and NHS to ensure it maximises the opportunities for the growing number of pharmacist independent prescribers to use and maintain these skills across healthcare settings, including in community pharmacy.

14. We are encouraged to see the enthusiasm of Integrated Care Systems to support the community pharmacy pathfinder sites that will explore the different models of pharmacist independent prescribing in a community pharmacy setting.[13] The provision of prescribing from community pharmacy needs to be supported by system-wide integration, supported by digital infrastructure. We welcome the recent announcement within the Primary Care Recovery Plan for further investment in digital interoperability. However, this investment needs to be more substantial and with closer alignment to system providers and meeting agreed national standards for operability. More funding should be available for the provision of clinical services as these need to be supported in terms of resource for IT and training.

15. Changes to medication supply arrangements, such as Hub and Spoke supply are potentially a way of taking the assembly of prescriptions out of the pharmacy, thereby freeing up pharmacists' time to undertake more clinical roles. This process has not yet been agreed or enabled in legislation.[14] There is further opportunity to enhance the skill mix within community pharmacy settings. We are encouraged by the recent commitment to consult on Supervision legislation this summer. However, a summer consultation suggests that practical change is unlikely to be realised until mid-2024.

Integrated Care: Community Pharmacist Consultation Service

"Deliver a new Community *Pharmacist Consultation Service with referrals from NHS111, GPS and A&E."*

16. Care offered by pharmacists working in the community must be part of integrated pathways to ensure that patients receive consistent and joined up care. The current systems used for the service make it harder for GPs and pharmacies to interact. Individual referrals take significant time. Pharmacists need to be part of the teams that develop the integrated care pathways to ensure the services they offer are part of the pathway.

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643520/Pharmacy_a_way_forward_for_public_health.pdf
[11] https://www.gov.uk/government/publications/healthy-living-pharmacy-level-1-quality-criteria
[12] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/
[13] https://pharmaceutical-journal.com/article/news/all-integrated-health-boards-in-england-submit-bids-for-pharmacy-independent-prescribing-services
[14] https://www.gov.uk/government/consultations/hub-and-spoke-dispensing

17. Significant challenges result from the lack of access to patient data and interoperability to allow pharmacy staff to see, document and share clinical information with other healthcare professionals. All pharmacists in the community must have read and write access to the electronic patient record. The Government has not gone far enough in making this a reality. Interoperability and access will enable pharmacists to ensure the care they are providing complements, rather than duplicates, that being offered by other healthcare providers. We are encouraged by the commitments to this access under the Primary Care Recovery Plan, but it remains to be seen as to whether this will go far enough.

18. There was no fixed deadline in terms of all pharmacies and all GPs being able to provide and undertake the CPCS. The Winter Access Fund in 2021 encouraged GPs to sign up to the CPCS service by December of that year. [15] Despite the ambitions to increase their referral rates to the CPCS they have failed to deliver the results.

19. The Government has stated that as of March 2023, 80% of all practices are connected and able to refer with 85% of those actively referring[16], although there is limited recent data available on overall referral numbers or regional variation. The revised *NHS oversight framework 2022/23* now includes indicators for completed CPCS referrals from general practice and NHS 111.[17]

20. There are several impediments to the delivery of this valuable service which the RPS highlighted in our 2021 joint report with the RCGP.[18] The reports demonstrates that there is lack of funding in terms of:
    - Additional investment in project management support on the ground including teams who would work with LMCs, LPCs, PCNs, GP practice, and community pharmacy teams to support engagement, drive service implementation and project delivery.
    - Additional investment in software technology to support easy referrals.
    - Additional investment in developing and supporting general practice reception teams and practice managers to help implement the service. This should include resources to explain the service to patients, CPD opportunities to support their understanding the role of community pharmacy, the CPCS referral pathway, the benefits of the service, how it will help manage/optimise workload, and how to manage referral cases.

21. Any national evaluation of the service needs to be shared more widely, including the impact on health inequalities as well as impacts on general practice workload and patients' outcomes.

22. We are pleased to see the expansion of the CPCS as announced on 9 May to include the supply of certain Prescription Only Medicines (POM) through national PGDs and the use of Pharmacist Independent Prescribers in Community Pharmacies, similar to 'Pharmacy First' and 'Pharmacy First Plus' services in Scotland.

23. There needs to be national and local engagement and communication plans in place for this service to be taken up and supported locally. There also needed to be public-facing communications on accessing primary care, including the role of community pharmacists to treat minor ailments and seeing the right healthcare professional at the right time.

24. Transfer of information between care settings continues to be challenging. There needs to be support available to develop easier general practice referral/triage functionality and interoperability with community pharmacy IT systems, so that all members of the general

[15] https://www.england.nhs.uk/wp-content/uploads/2021/08/B0828-iii-annex-b-investment-and-impact-fund-21-22-22-23.pdf
[16] https://questions-statements.parliament.uk/written-questions/detail/2023-03-28/175564
[17] https://www.england.nhs.uk/wp-content/uploads/2022/05/B1378_ii_nhs-oversight-metrics-for-2022-23_June-2022.pdf
[18] https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/cpcs

practice teams or patients who wish to make an appointment are diverted to an appropriate appointment type, with an appropriate person, at an appropriate time.

25. The service referral pathway also needs to be streamlined through the use of e-consultation platforms/algorithms to triage a patient and refer them to community pharmacies from general practice. As described elsewhere the investment in the digital infrastructure in community pharmacy continues to be very limited.

26. There needs to be national investment in general practice and community pharmacy systems to enable seamless integration and exchange of clinical information for incorporation into the patient medical record as required. A clear roadmap and timeline around complete read/write access to medical notes for community pharmacy is needed. This will ensure further integration of community pharmacy across the NHS and enable better continuity of care for patients.

27. While the ambition to deliver CPCS service has been met, it has not had the sufficient resource, workforce, and implementation support to make it the potential success it could be.

Integrated Care: Discharge Medicines Service

"Introduce a medicines reconciliation service to ensure that changes in medicines made in secondary care are implemented appropriately when the patient is discharged back in the community ('Discharge Medicine Service')."

28. In October 2022, the Pharmaceutical Journal reported a significant variation in implementation of the Discharge Medicines Service.[19] At the time, 27% of NHS trusts had not yet implemented the service.

29. The Pharmaceutical Journal reported that some trusts had said they were waiting for suitable IT systems before moving forward with the service, despite funding being available. The DMS has been included in Commissioning for Quality and Innovation (CQUIN) since April 2022.[20]

30. This indicator directly incentivises acute trusts to make a referral into the NHS Discharge Medicines Service which is compliant with the minimum quality requirements described in the NHS DMS Toolkit. Patients who are supported by this service are less likely to be readmitted (5.8% vs 16% at 30 days) and spend fewer days in hospital (7.2 days on average compared to 13.1 for patients who did not have access to the service) where they are readmitted.[21]

31. NICE NG5 recommends that medicines-related communication systems should be in place when patients move from one care setting to another, and the act of reconciling medicines should happen within one week of the patient being discharged.

32. Patient groups who are potentially suitable for DMS referrals were included in an NHS England toolkit[22] for pharmacy staff in community, primary and secondary care. However, it adds that "actual referral criteria should consider local population needs and the NHS trust's capability to refer patients". In October 2022 the Pharmaceutical Journal reported that 19 trusts said they did not have eligibility criteria for DMS referrals, with some saying this was because all patients are offered a referral at discharge. 14 trusts said they were limiting DMS referrals to one patient group, with some planning to expand to further groups in the future.

[19] https://pharmaceutical-journal.com/article/feature/missed-opportunities-the-patients-falling-through-the-cracks-after-discharge
[20] https://www.england.nhs.uk/wp-content/uploads/2022/12/CQUIN-2023-24-guidance-version-1.1.pdf
[21] https://pharmaceutical-journal.com/article/news/quarter-of-referrals-under-national-hospital-discharge-service-from-just-one-area
[22] https://www.england.nhs.uk/wp-content/uploads/2021/01/B0366-discharge-medicines-toolkit.pdf

33. The available data shows a significant variance in the number of DMS referrals made by acute trusts. Further efforts to drive consistency in approach and service delivery would aide this ambition being met. Digital solutions are required. The Health Committee's Expert Panel has already commented on the challenges in digital transformation.[23]

Hospital Pharmacy: Electronic Prescribing

"To eliminate paper prescribing in hospitals and introduce digital prescribing across the entire NHS by 2024."

34. The implementation of electronic prescribing systems within NHS Trusts is varied, and associated with many challenges that are known to the Committee.[24] Electronic prescribing in hospitals is not universal.

35. We have heard that even where electronic prescribing has been implemented there are still areas across some Trusts that are not using electronic prescribing due to poor capability of the system to provide the functionality needed, such as A&E departments and outpatients. Even those patients prescribed medication digitally may also be prescribed medication on paper. Some Trusts have multiple paper prescription charts in use across the Trust alongside the electronic prescribing system (approximately 70 different types of paper prescription charts) for items such as fluids and complex infusions. Barriers to eliminating these paper charts relate mainly to resource, for example, the functionality/module is available in the electronic prescribing software for complex infusion prescribing and administration, but resource in terms of equipment, staff, funding and IT infrastructure have hindered implementation.

36. There is a commitment within NHS Trusts to achieve a reduction in paper prescribing, but it is very unlikely that this will be achieved in 2024. This is due to a number of factors.
    - Funding available to achieve interoperability across all prescribing interfaces, also systems have not been designed to achieve the Information standard DAPB4013 or see any obligation to achieve this without charging considerable development fees.
    - Functionality of systems available to achieve paperless prescribing in outpatients, ward attenders, treatment centres due to systems functionality being designed to meet standard in-patient prescribing only.
    - Expertise of staff and available informatic pharmacy staff to configure the systems to achieve this.

37. Also, whilst the commitment to the implementation was well resourced in terms of staff support, what was not recognised and is certainly under recognised and under resourced now, is the transformation projects required after implementation to maximise system functionality and to continue with upgrading and improving the system. The funding is only partially covering the commitment required, this is due to limitations of funding available and understanding within the Trust of the resource requirement to achieve the project and business as usual demands and the optimisation requirements to keep the system and operational processes developed to meet the benefits planned. Additional funding is required, for example:
    - On-call team to support the system 24/7.

[23] https://committees.parliament.uk/publications/33979/documents/186799/default/

[24] https://committees.parliament.uk/publications/33979/documents/186799/default/

- Interoperability resource to develop integration with in-house or commercial systems.
- Technical resource to develop or deliver business continuity solutions.
- BAU staffing to optimise the staff, develop new ways of working and design add on tools to support operational use of the system.
- Resourcing reporting and data mining.
- Slippage of the projects deliverables due to failure of suppliers to meet deliverables/system upgrades/fixes.

38. In addition, whilst there were funds to support purchasing and implementation of the electronic prescribing system, the choice of system was restricted by what each Trust could afford, so they were limited as to what they could financially afford rather than what they wanted in terms of functionality.

39. The electronic prescribing system has brought benefits to both patients and staff, and these are well documented in the literature, e.g., no more ambiguity with poorly written prescriptions, no more charts getting lost, eradicating time spent re-writing drug charts. But with digital systems there are unintended consequences which can have detrimental effects, such as alert fatigue which can result in errors, more time is needed to manipulate the system to complete tasks, there is a greater cognitive burden to completing tasks digitally rather than on paper and changes to communication flow between staff and patients.

40. The commitment to electronic prescribing is well intended, but the time needed to implement these systems is unrealistic and the commitment ambiguous. There is a view that some hospitals might feel the push, rush implementation and end up in a situation with a hybrid economy with prescriptions. Additionally, it is worth noting that the emphasis for these projects sits mostly with the technology, and little attention or focus is given to the people part of digital system use. There needs to be a step change in how we implement this technology, both within organisations and across the wider healthcare system, because the current approach does not engage with the workforce and this is creating barriers, a disconnect and resistance to change. Technology needs to be built in collaboration with the clinicians using it and the patients that will benefit from it. Again, this is something that has been evidenced in previous submissions to the Health Committee.

Hospital Pharmacy: Aseptic Services

"To optimise NHS aseptic services to deliver better clinical outcomes for improved patient experience and to achieve productivity gains. Various targets around standardisation, automation via hubs to increase capacity to 40 million units of aseptic preparation."

41. There have been untimely delays including the Covid-19 pandemic and as a result the commitment is not on track, but it is in progress.

42. Whilst it is understood more funding may become available if pathfinder sites are successful, resource and funding has been insufficient to date to deliver a full transformation process. Initially £225 million was requested to deliver the project, however only £75 million has been made available, hence only 5 "pathfinder" sites have been funded.

43. As the commitment is still work in progress it has not yet achieved this impact. However Ready To Administer (RTA) batches made via standardisation and automation methods via hubs will improve quality and availability which will undoubtedly have positive impact on patients and

those healthcare professionals who are involved in the preparation and administration of these medicines.

44. We believe that the commitment is appropriate, however the strategy to deliver the commitment does not go far enough. The focal point to date has been around production facilities. There has been little focus on National QA standardisation and central QC services which are essential for the infrastructure for this project.

45. Additionally, the changes in the pharmacy undergraduate degree course and pharmacy technician course have contributed to a severe shortage in the technical service workforce. At present there is no clarity on how the workforce shortage will be addressed. Utilisation and technical training of pharmaceutical scientists and other groups must be considered as a priority to ensure Hubs have capacity.

Workforce, Education and Training: PCN and Community Pharmacy Training

"A further 3-year programme of education and training for PCN and community pharmacy professionals is being commissioned from Health Education England and it will include independent prescribing training for existing pharmacists."

46. Members of our Expert Advisory Groups have in general welcomed this education and training programme, backed by more comprehensive funding compared with previous schemes. We have seen an increase in pharmacists and pharmacy technicians in post within GP practices, but some members have called for a movement towards higher funding brackets and further expansion of the scheme. For example, the Additional Roles Reimbursement Scheme only provides for funding up to Agenda for Change Band 8a, which is likely to encourage either development inertia or a move towards other roles which are better suited to same-day care rather than long-term conditions expertise. There needs to be further investment and development of the Consultant Pharmacist pathway in Primary Care.

47. The ARRS scheme has been a positive impact for patients and service users, including improved medicines optimisation, creation of specialist roles in primary care that allow pharmacists to run specialist clinics and free up waiting times, increased volume of research, improved access to appointments and vaccination leadership during the Covid-19 pandemic.

48. The uptake of pharmacists into PCNs and General Practice has been significant, but this has had an impact on areas that have seen issues with pharmacist retention, such as community pharmacy. There needs to be a renewed focus on upskilling pharmacists who remain in community roles, and creating a framework that allows them to use their clinical skills and knowledge without creating additional risk or duplication of services for patients. Some community pharmacy contractors have warned about significant barriers to access to education and training opportunities, including the lack of protected time for staff training, as well as the affordability of professional development and the potential impact of workforce retention.

49. We have heard that one of the issues that has been difficult to navigate has been site resources and facilities. For example, although the number of clinical staff has increased, the number of clinical rooms has stayed the same, which means pharmacists are often left with telephone and remote clinic services whilst they work out of an office, or even at home. This needs to be addressed as part of the wider issue around property services and how practices can be supported to expand physically as well as from a workforce perspective. There have also been

challenges and pressures in terms of clinical supervision from GPs and the time and funding needed to undertake supervision of new pharmacy roles.

Workforce, Education and Training: Legislative Changes and Skill Mix

"Propose legislative changes that will allow for better use of the skill mix in pharmacies and enable the clinical integration of pharmacists."

50. Skill-mix optimisation is about using people in the right role for the task in hand. Workload pressures can be eased for pharmacists where they are able to delegate tasks. Consideration should be given to all members of the team, not just those who are most qualified. Historically, there has been a requirement for certain medicines to be sold only by, or under the supervision of, a pharmacist. The concept of "supervision" is referenced in the Medicines Act 1968 and the Human Medicines Regulations 2012. Community pharmacy practice has advanced significantly since the legislation. Significant contextual change to the operation of community pharmacy means there is now uncertainty over the definition of "supervision" and its impact on the professional practice. Through the Primary Care Recovery Plan the Government committed to bring forward a consultation on supervision legislative changes this summer.

51. Changes in the supervision requirements will enable the better use of skill mix in pharmacies. We are actively pushing the Government to accelerate this discussion, but so far, they have not met their commitment to propose legislative changes.

52. In contrast we have seen some positive legislative change in relation to the roles and responsibilities of Responsible Pharmacists and Superintendent pharmacists. The legislative changes in 2022 gave the GPhC, rather than ministers, the powers to clarify the roles.[25] The Department also made progress in publishing it's response in April 2022 to the 2018 consultation on rebalancing medicines legislation. This sets out an agenda for rebalancing the legislation and paving a way forward for exploring the supervision legislation further.

53. Making best use of the skill-mix takes leadership and needs support from the across an organisation. Appropriate leadership and management training should be made available to all those in senior positions across the NHS (including in community pharmacy) to support the delivery of skill mix changes. More training opportunities in enhancing understanding of scope of practice are needed but these should be properly resourced in terms of time and funding.

54. Recent commitments regarding the changing role of pharmacy technicians in relation to PGDs and VAT on PGDs also represent positive steps in embracing wider skill mix in pharmacy settings. We are encouraged by the recent commitment to consult on Supervision legislation this summer. However, a summer consultation suggests that practical change is unlikely to be realised until mid-2024.

Extended Services: Prevention and Detection Services

"Test a range of additional prevention and detection services through the Pharmacy Integration Fund, which if found to be effective and best delivered by community pharmacy, could be mainstreamed within the CPCF."

[25] https://www.legislation.gov.uk/uksi/2022/849/pdfs/uksi_20220849_en.pdf

55. Our 2022 report with The King's Fund highlighted a key role for community pharmacy to support prevention and early detection if appropriately resourced.[26]

56. An estimated 1.6 million visits to community pharmacies take place daily, of which 1.2 million are for health-related reasons.[27] This regular contact, without the need for an appointment, means pharmacists are well placed to provide opportunistic health education, advice and support and to make every contact count. Pharmacists need to be supported to give people the information and tools to make positive lifestyle choices and to engage in self-care.

57. When someone first starts to experience the symptoms of ill health, they may initially attempt to self-manage and will often seek advice from a pharmacy; this is an ideal opportunity for pharmacists to detect the early indictors of what could be a long-term condition. The current system needs to change to enable referrals between different care providers, and particularly between general practice and community pharmacy. Pharmacists should be able to directly refer to other health and social care professionals as part of the wider system.

58. Pharmacy teams will continue to play a crucial role in vaccination programmes, including Covid-19 and flu, and engaging with their communities to overcome vaccination hesitancy.

59. Pharmacists already conduct several screening programmes for long-term conditions. Three services were piloted and introduced within the CPCF – Hypertension Case Finding Service, Smoking Cessation Service and the Pharmacy Contraceptive Service. While NHSE has conducted evaluations of these services, the evaluation reports have not been published in full.

60. There has been positive engagement with the Hypertension case fining service, with approximately a million checks completed in community pharmacy since the service launched. Referral processes and changes in parts of the NHS are required to make the Smoking Cessation Service a success. To date the number of referrals has been smaller than expected. However, more opportunities for simple testing for long-term conditions should be explored as part of a preventative approach to healthcare, for example atrial fibrillation detection, blood pressure monitoring for hypertension and testing blood glucose levels for diabetes.

61. Sexual Health prevention through the Pharmacy Contraceptive Service has been more limited. The service has only recently started, with many contractors choosing not to engage with the service due to insufficient funding within the CPCF. However, the recent Primary Care Recovery Plan does provide some commitment to additional funding to support the expansion of this service. The HIV Action Plan set out an intention to explore the provision of pre-exposure prophylaxis (PrEP) via community pharmacy, which was welcomed by the RPS and other pharmacy and patient groups, but progress has been slow. Recent media reports have noted proposed pilots, but these are yet to be taken forwards.[28]

62. As with other services in community pharmacy, the IT infrastructure is still lacking. APIs are required to ease interoperability between systems, to which NHSE need to lead by publication of technical specifications and further technical developments at the interfaces of care.

The Royal Pharmaceutical Society

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[26] https://www.rpharms.com/england/vision-for-pharmacy-practice-in-england
[27] https://digital.nhs.uk/services/podac/pharmacy
[28] https://pharmaceutical-journal.com/article/news/national-pilots-for-prep-access-from-community-pharmacies-recommended-by-government-advisers