

# Supporting the Development of Community Pharmacy Practice within Primary Care



## Foreward

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Much has been written recently about how clinical pharmacists can work within GP Practices to improve access for patients by reducing pressure on an ever-dwindling number of GPs. Clinical pharmacists in GP Practices appear to be viewed at the cavalry appearing over the horizon. The co-location of pharmacies within health centres is also seen by some as the universal place for patients to be dispensed their medication, as if purely co-locating disparate services in the same building automatically leads to fully integrated care. These two viewpoints miss the very important role played by retail pharmacy on our high streets and in our supermarkets. Patients, on the whole, feel far more comfortable walking into a high street shop rather than into a health facility. It is also one of the only places where a person can walk in and ask to speak directly to a health care professional. Yet we are increasingly moving this clinical workforce into GP Practices, where patients have to run the gauntlet of receptionists and appointment systems in the name of “improving access”.

The NHS Alliance agrees with Dr Keith Ridge that there is an ‘unprecedented demand for clinical pharmacy’. We have led with our report ‘Pharmacists and General Practice’ and our work on Urgent and emergency care.

Simon Stevens, with the 5 year forward view explained that ‘we need to get serious on three fronts: we need to take our own health seriously, change the way that services are provided and ask the government to support us financially to carry on delivering high quality services’. However, the NHS Alliance does not agree with Sir Bruce Keogh that the ‘NHS can cope with increasing demand through better prevention and greater efficiency of care’ without developing a forward view for community pharmacy.

Community pharmacy in England, with approaching 11,700 pharmacies, represents health on the high street and within our communities. The NHS needs clinical pharmacists within General Practice, urgent care and out of hours, nursing homes and many other multidisciplinary teams. But the NHS also needs clinical pharmacists within a community pharmacy setting and a strategy for community pharmacy to deliver its potential.

There is no community pharmacy led Vanguard or PM challenge fund program despite Simon Stevens assurance that we ‘need to take action on four fronts:

- Tackle the root causes of ill health
- Give patients more control of their own care
- Change to meet the needs of an aging population, living longer with long term conditions and wanting their care to focus around them
- Deliver new models of care

We must recognise community pharmacy as a professional clinical retail healthcare environment and as an integral member of the primary care team. We must also recognise the pharmacy's unique position within the community and their ability to reduce demand within General Practice as part of the solution to the crisis within General Practice.

The NHS Alliance would therefore like to bring a balance to the discussion about the future development of pharmacy services by emphasizing how high street pharmacy provision can enhance patient care within a multi-faceted integrated model.

A handwritten signature in black ink, appearing to read 'M Spencer'.

**Dr Mark Spencer**  
*Co-Chair NHS Alliance*



## Executive Summary

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The NHS Alliance remains disappointed that there is not a community pharmacy led new model of care and that the NHS has failed to fully utilise the expertise of the community pharmacist within their locations in the heart of many communities. We would like to suggest:

- NHS England pays specific attention to commissioning a community pharmacy led new model of care looking to fully utilise the pharmacist's expertise within the heart of communities
- GPs must support community pharmacy as the first call point for patients with acute self-limiting conditions and minor ailments, both as commissioners and partners in delivery
- GPs, community pharmacy representatives and Government should work together to reclassify medicines and reconsider NHS reimbursement
- GPs should play a lead role in ensuring that complete pathways of care are commissioned that avoid duplication of effort
- GPs should identify element of holistic care that can be identified as self-care opportunities for delivery within a community pharmacy
- GPs have a leading role in the commissioning and development of services from community pharmacy
- The GPs should identify situations where, once the diagnosis has been made the complete care of that condition can be transferred to the community pharmacy under an agreed treatment protocol
- Directors of Public Health, CCG commissioning leads, GPs and Community pharmacy representatives should create a local plan to support community pharmacies in delivering a consistent public health message and associated services to their catchment population

## Introduction

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Primary care faces four important threats:

- Financial shortfalls
- GP workload
- Community Pharmacy development
- Patient expectation

## NHS Financial Shortfalls

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As the demand on services grows the budget for the NHS does not seem to be growing at the same pace. The 5 year Forward View acknowledged a £30m funding gap by 2020 and put in place a plan in which the NHS would drive £22b of efficiency savings and the Government would increase NHS budgets by £8b. At this stage a whole plethora of new models of care are in place, but the majority of the savings have been driven centrally including the proposed cuts to community pharmacy funding of 6%.

## GP workload

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GP workload is increasing in a time where recruitment is difficult. Much can be done to improve skill mix in General Practice and the NHS Alliance have supported the Practice Pharmacist and the Practice Nurse agendas. However, demand is increasing and unless there is a mechanism to control and reduce demand the progress made within the General Practice Forward View may seem a mere sticking plaster.

The GPs should focus their attention to patients that actually need their level of expertise to diagnose and manage the treatment within their teams. Any patient that could be adequately managed by the Community Pharmacist should be referred there to reduce practice workload and encourage positive patient behaviours towards self-care and management.

## Community Pharmacy Development

The NHS Alliance has consistently said that community pharmacy is an underutilised asset within the NHS family. They are the front line professional retail element of healthcare and the focus of self-care for the population. There is little doubt that technology will make the ordering, dispensing and delivery of medicines more convenient for some patients and NHS England believes that the introduction of automation will allow the NHS to make savings. There are fears that a reduction in income for community pharmacy will disrupt the network and cause closures. Should a pharmacy close then patients will be inconvenienced and the workload on nearby GP practices could be expected to increase.

NHS England with the PSNC and representative organisations are working to understand and develop the possible clinical roles of the pharmacist. There is no doubt that the roles of the pharmacist within General Practice, A&E services and care homes are high on the priority list, but there needs to be a focus on the clinical potential of the pharmacist within community pharmacy. This is associated with plans to ensure the delivery of high quality care both independently of and in partnership with General Practice and other NHS providers.

There have been many documents scoping out the vision for community pharmacy. The NHS Alliance believes that we have made too little progress in their implementation and it is time for more proactive action.

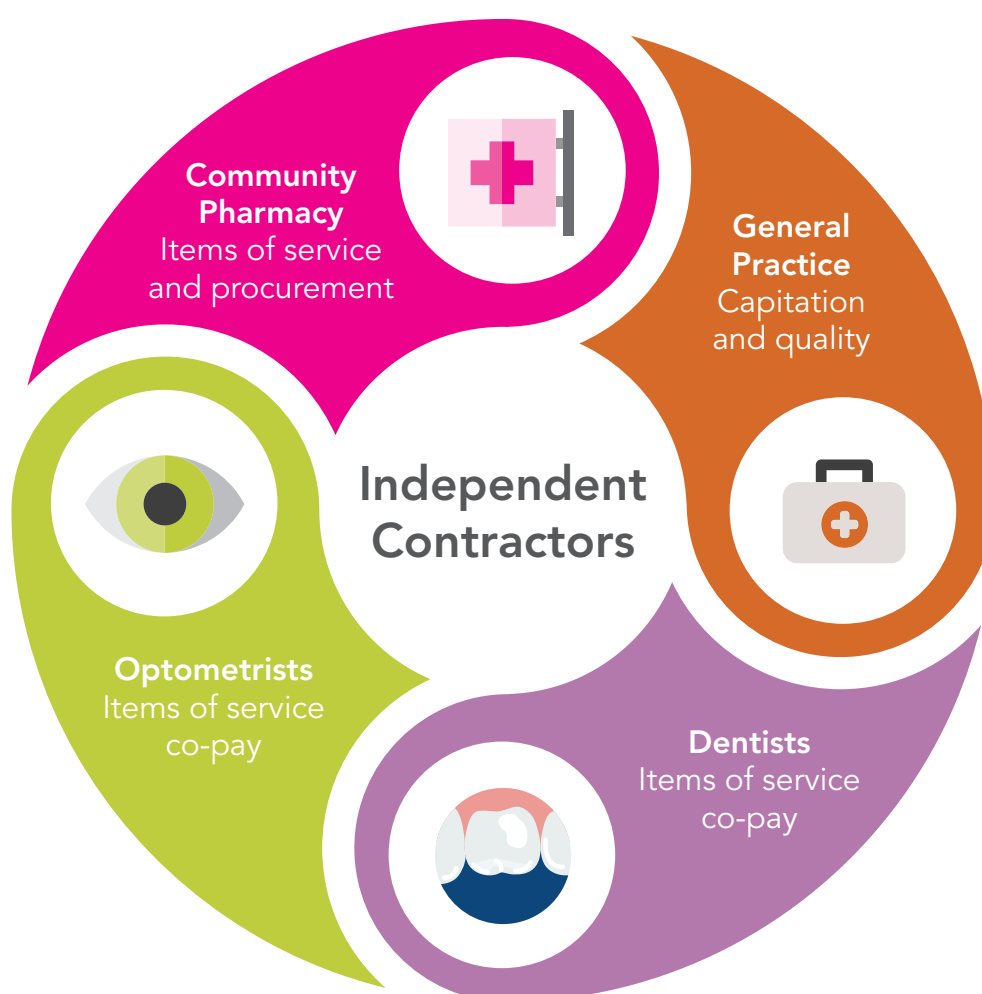
## Patient Expectation

Many articles and reports have shown that patient's expectations are increasing. Patients are expecting quicker access to high quality services; they expect to get answers almost instantly and at their convenience at times outside the normal opening hours of some NHS services. When GP practices are not open, patients will increasingly seek help from urgent care centres and A&E services. As these open or expand they drive further patient expectation and unwanted behaviour. It can seem a never ending spiral of expectation and increased service provision.



## Independent Contractors

The NHS works with four primary care based independent contractor services – General Practice, Community Pharmacy, Optometrists and Dentists. Each of these four main contractors operates as independent businesses each with an individual contract with the NHS. Within each sector there is a variation of business models between limited liability partnership, private limited companies and public limited companies. The components of each contract is very different with some services such as dentistry and optometry including significant elements of co-pay and others driven by items of service or a mixture of capitation and quality. The one thing that draws many of these contractors together is that they are all individual business and need to have income to cover all expenses to survive and a surplus to be able to invest in service development.





## Community Pharmacy

There are nearly 11,700 community pharmacies in England. Each pharmacy serves a catchment population of approximately 5,000 people. It is widely quoted that 1.6m people walk into a pharmacy every day meaning that there a pharmacy may have 136 people that walk in every day. Many of these pharmacies are open extended hours and many over 85 hours a week.

All community pharmacists have significant clinical training within their degree course and pre-registration training. This is further developed in practice and through continual professional development. All community pharmacies have an area reserved for confidential conversations with people away from the main counter area. These private consultation areas have been extensively used within the NHS England commissioned Medicines Use Review (MUR) and New Medicines Service (NMS).

The location of community pharmacies is important. We may describe locations as major retail, high street or within or close to General Practice. These descriptions do not fully value the position of community pharmacies within rural and deprived communities. The NHS often speaks about 'hard to reach' communities and many pharmacies provide a valued healthcare setting as a companion service to general practice. Many pharmacists have developed their practices with 'Healthy Living Pharmacy' and 'Self-care Pharmacy' concepts including health champions as members of staff.

Many services are already commissioned with community pharmacies which have shown the pharmacies' competence is reaching varied populations and delivering a variety of services. Many of these services have included physiological measurements, blood tests or sampling (for example chlamydia testing).

**5,000 people  
catchment population**



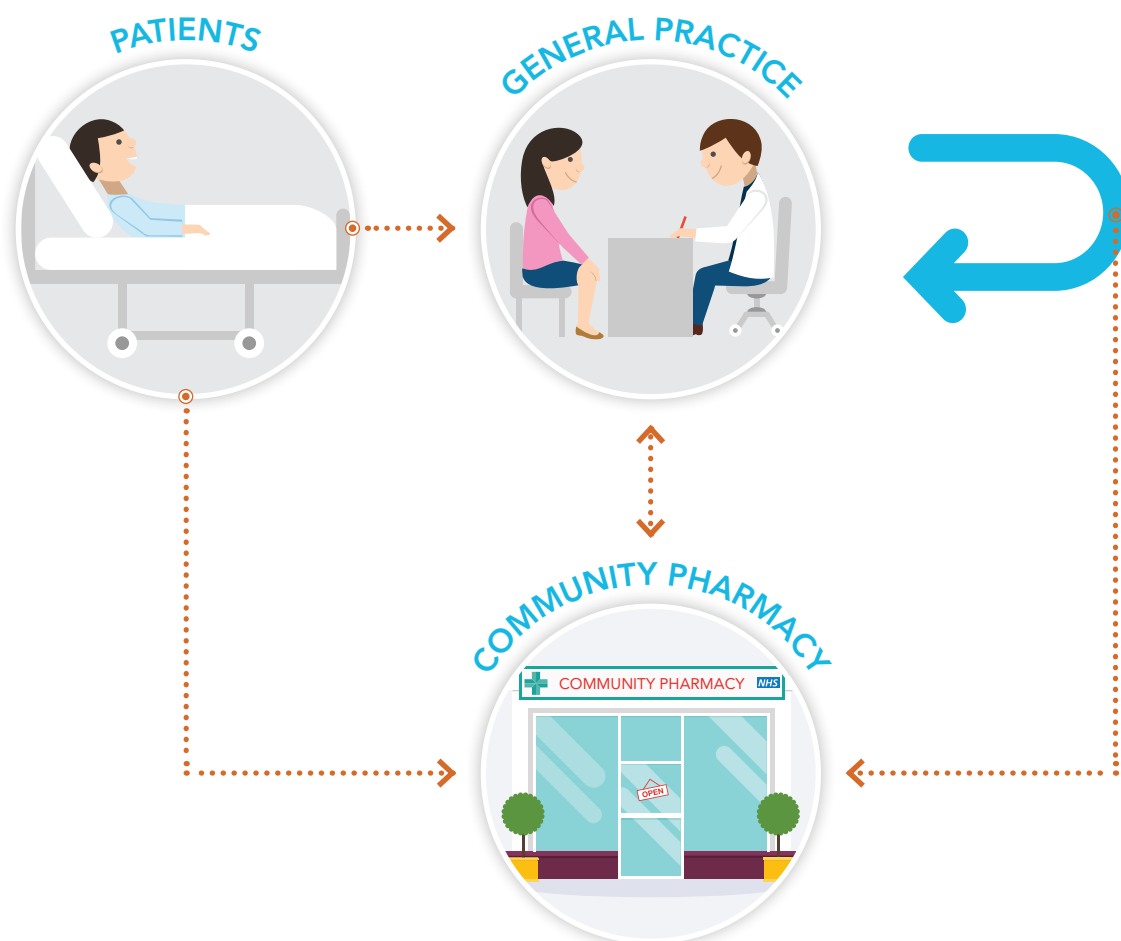
**VISITING  
PHARMACY**

**136  
people/day**



## Managing Demand in General Practice

The NHS Alliance / Primary Care Foundation report – “Making time in General Practice”, highlighted many of the bureaucratic difficulties that General Practice face in the operation of their healthcare business. Improving payment mechanisms, processing information from hospital, keeping up to date with changes and reporting information all featured as important issues to manage. 27% of GP appointments were considered to be avoidable and 5.5% of all appointments could have been managed within the community pharmacy.



Demand Management in General Practice may take several pathways.



## Avoiding Appointments

Many patients with acute self-limiting illnesses should be diverted to community pharmacy. The DH and PHE have invested heavily in campaigns to persuade people to visit their Community Pharmacy first and to visit early before symptoms have become difficult to manage. This falls into the general competency of community pharmacists. The book "Minor Illness or Major Disease?" originally authored by Stillman and Edwards was produced many years ago and has been regularly updated since. It has been part of the undergraduate curriculum and part of essential reading for community pharmacists over two decades.

Some CCGs in England have commissioned a service that both pays the community pharmacy for the intervention and supports the supply of specific medicines to patients that would not normally pay for their prescriptions. The service in England can only be described as piecemeal and where Scotland has a developing national service, the service in England is being reduced.

GPs should reflect on the ability of community pharmacy to reduce demand on General Practices and ideally support the commissioning and the delivery of these services.

An estimated 57million appointments a year are used by people with common conditions or medicines-related problems. Pharmacists may have considerable experience of managing these within a community pharmacy setting.

NHS alliance. Making time in general practice. Available at: <http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-01-10-15.pdf>. Date accessed June 2016

"The new unified scheme has delivered, on average, two hours per week per practice of additional GP appointment capacity as well as a 46% reduction in costs in comparison to the same quarter the previous year."

*NHS England Birmingham, Solihull & the Black Country, Pharmacy First evaluation*

NHS England Birmingham, Solihull & the Black Country. Pharmacy First – Liberating Capacity. Available at: <http://psnc.org.uk/dudley-lpc/wp-content/uploads/sites/78/2015/02/Final-V2-Pharmacy-First-Liberating-Capacity-Feb-2015-pdfv.pdf>. Date accessed June 2016

5.5% of all GP appointments could have been seen by community pharmacy or the patient could have been given support to deal with the problem through self-care.

NHS Alliance. NHS alliance publishes new report, making time in general practice. Available at: <http://www.nhsalliance.org/mediacentre/making-time-in-general-practice/>. Date accessed June 2016

## Supporting Community Pharmacy based minor ailment schemes

Support commissioning and development of locally funded services.

Signpost patients to pharmacies for acute self-limiting conditions.

Introduce supportive materials within the practice to support patient understanding and self care.

Work with local pharmacists to develop local understanding, confidence and develop trust.

Refer patients when booking appointments or within consultation to community pharmacy.

Public Health England, NHS England and other organisations produce campaign posters signposting patients to community pharmacy. These create awareness of pharmacy capabilities and form the basis of further conversations.

Organisations such as the Self-Care Forum produce a range of simple materials that can be used to support self-care discussions within consultations and the Global Respiratory Infection Partnership (GRIP) produce leaflets to help people understand the duration of viral respiratory illness symptoms. These materials can support the referral to community pharmacy for symptomatic relief.

Some GPs may feel uncertain of the community pharmacy capability. It is important for the GP to build a working relationship with the community pharmacy team to build confidence and trust that their patients will be well managed. The community pharmacist will undoubtedly gain experience in how to deal with tricky situations and sharing of experience and treatment strategies would be beneficial. We would like to see GPs and community pharmacists meeting on a regular bases to discuss treatment protocols and case presentations.



The practice could implement more formal procedures when booking patients into appointments to see whether a visit to the community pharmacy would be suitable. A simple question – “what did your community pharmacist say” may have a significant effect on the pathway.

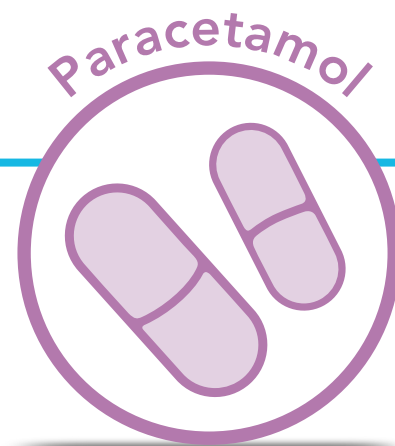
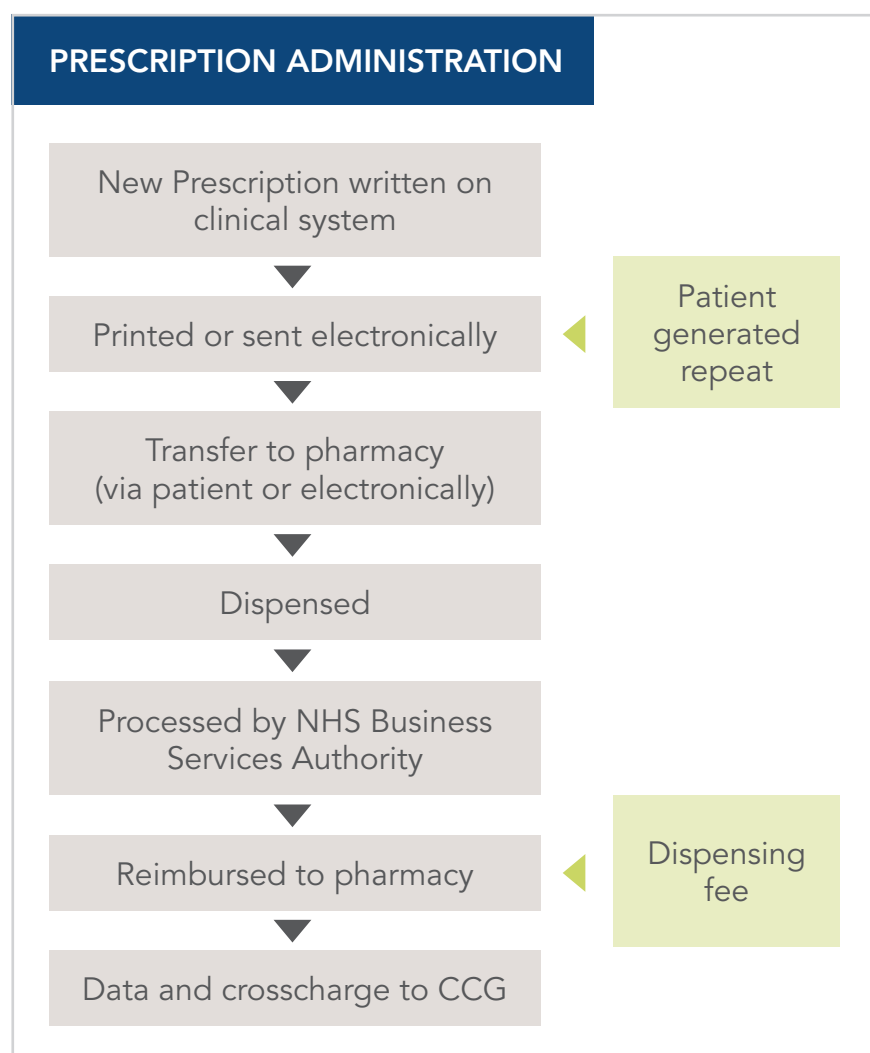
The GP Forward View includes a specific directive that GPs have an important role in the commissioning of community pharmacy services. A service may have three payment points – an establishment fee to cover the set up costs for a higher level of service provision – an intervention fee that covers the time commitment to see patients in a formal setting, particularly where no medicine is sold – and a supply fee that covers the cost of the medicine supplied to patients that do not have to pay for medicines and would be likely to visit a GP for this supply.



#### KEY MESSAGE

***GPs must support community pharmacy as the first call point for patients with acute self-limiting conditions and minor ailments, both as commissioners and partners in delivery***

## Over The Counter (OTC) medicines in an NHS context



**22 million**  
prescriptions for  
paracetamol dispensed  
in 2015 in England  
which cost  
**£87m**

Health and social care information centre.  
Prescription cost analysis England 2015.  
Available at: <http://www.hscic.gov.uk/catalogue/PUB20200/pres-cost-anal-eng-2015-rep.pdf> Date accessed June 2016

There are three classes of medicines;

- Prescription Only Medicines (POM) which generally are only supplied to a valid prescription or within a Patient Group Direction (PGD). These may be sold to a valid private prescription or within a private PGD
- Pharmacy Only (P) which are generally medicines that can be sold under the supervision of a pharmacist within a registered pharmacy
- General Sales List (GSL) which are medicines that are available widely with certain restrictions, for example pack size

The Department of Health have progressed medicines from POM to P and from P to GSL to increase availability of some medicines and offer greater choice and convenience to patients. These moves should be supported and extended.

The NHS pays for any medicinal product listed within the Drug Tariff. This tariff sets the reimbursement price – the price that the NHS pays community pharmacy. There is a list of medicines that are not reimbursable which means that a GP can prescribe them, but the community pharmacy would not be reimbursed for the supply. The Department of Health should work closely with GPs and Community Pharmacists to determine which medicines could be safely moved to this list to discourage GPs from prescribing some simple medicines to patients. Paracetamol alone costs the NHS £87m within primary care a rise of 8.75% over the previous year. It is not only the cost of the medicine, but the administration costs associated with secure stationery, prescription writing, dispensing, costing and reimbursement that should be considered. The NHS undoubtedly spends in excess of £250m on medicines that could easily be purchased by patients direct from their community pharmacy.

#### GP views on the prescribing of OTC medicines

"The current policy was 'madness: We have many patients attending a £15 appointment to get a scrip for £1 of medication."

"Eliminating free prescriptions for drugs available OTC would help 'avoid unnecessary congestion in surgeries"

GPs also argued that 'medicine cupboard' items should be regarded as a basic household expense.

"It should be part of a parent's responsibility for having children to keep Calpol or Nurofen in the house and not depend on a prescription for this"

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GP online. No more free prescriptions for OTC medicines, say GPs. Available at: <http://www.gponline.com/no-free-prescriptions-otc-medicines-say-gps/article/1150020> Date accessed June 2016

#### KEY MESSAGE

***GPs, community pharmacy representatives and Government should work together to reclassify medicines and reconsider NHS reimbursement***

## Avoiding duplication of effort

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There are many examples where the community pharmacist may put all of the work in diagnosis and recommending an appropriate product only to find that the patient attends their GP to access a prescription that would be free from them (exempt from prescription tax). It is important that GPs, community pharmacies and the Clinical Commissioning Group identify ways of empowering community pharmacy and avoiding duplication.

For example some community pharmacies are commissioned to provide head lice treatment. It is not unusual for a patient to be identified as having headlice and the whole family unit is recommended to have a treatment. The treatment may amount to £20 which some people may find excessive, particularly when they are exempt from prescription tax and two or three are children who also do not pay for prescriptions. In this situation the community pharmacist, having delivered a 'service' is unable to make a sale and the patient chooses to visit their GP to get a re-diagnosis and a prescription.

It is not uncommon to find Chlamydia screening services commissioned without access to medicines. Community Pharmacists have explained that people with a positive diagnosis then decide not to purchase an appropriate medicine from the pharmacy, but to attend the GUM clinic (at a cost of nearly £150 to the NHS) or visit their GP practice for a suitable prescription.

### **The supply of medicine following a positive chlamydia test**

"This can be managed simply through the use of a PGD for community pharmacies, it can be more complex for general practice to deliver this."

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[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/373205/Developing\\_service\\_specifications\\_for\\_chlamydia\\_testing\\_and\\_treatment\\_in\\_GP\\_and\\_CommPharm.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/373205/Developing_service_specifications_for_chlamydia_testing_and_treatment_in_GP_and_CommPharm.pdf)

Pharmacists are able to supply medicines to patients in an emergency – for example when they are travelling and have left their medicines at home. The Shared Care Record has given the pharmacists the ability to check the medical record before making this supply to improve accuracy and reduce the opportunity for diversion. This supply, however, may require the patient to pay for their medicines and drives patients into out of hours services or General Practice as temporary residents. Some CCGs have implemented a service to underwrite the costs of the pharmacy and therefore reduce attendance at A&E and General Practice.



## PSNC. ESSENTIAL FACTS, STATS AND QUOTES RELATING TO THE EMERGENCY SUPPLY OF MEDICINES<sup>1</sup>

- Up to **15%** of calls to NHS 111 are for emergency repeat medication at busy times at the weekends and **3-4%** of bank holiday out-of-hours appointments with a doctor are taken up by requests for a prescription for repeat medicines
- Up to **30%** of all calls to NHS 111 services on a Saturday are for urgent requests for repeat medication

## NHS ENGLAND, NORTH MIDLANDS EMERGENCY SUPPLY SERVICE REPORT 2014/15<sup>2</sup>

- **44%** of patients who accessed the service said they would have accessed OOH GP services or A&E/Urgent care centres and **49%** said they would have gone without their medication if the services had not been available
- This service diverted **over 800** patients away from OOH GP services or A&E/Urgent care centres and enabled **over 900** patients access to medication they would not have sourced elsewhere

### References

1. PSNC. Essential facts, stats and quotes relating to the emergency supply of medicines. Available at: <http://psnc.org.uk/services-commissioning/essential-facts-stats-and-quotes-relating-to-the-emergency-supply-of-medicines/>. Date accessed June 2016
2. PSNC. PSNC Briefing 044/15: Analysis of Emergency Supply services – commissioned during 2014/15 in England. Available at: <http://psnc.org.uk/wp-content/uploads/2015/08/PSNC-Briefing-044.15-Analysis-of-Emergency-Supply-services-commissioned-during-2014-15-in-England-does-not-include-appendix-on-fees-available-to-all.pdf> Date accessed June 2016

### KEY MESSAGE

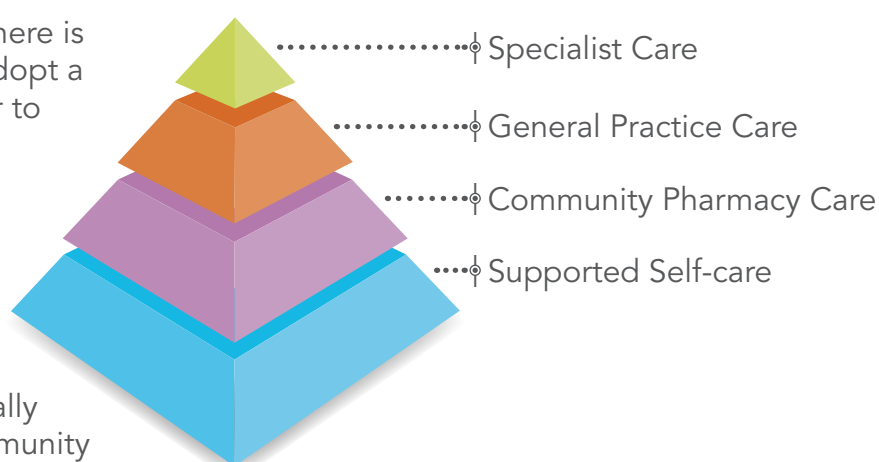
*GPs should play a lead role in ensuring that complete pathways of care are commissioned that avoid duplication of effort*



## Sharing Care

GPs should work closely with community pharmacies to share elements of care, rather than taking on the whole holistic care of the patient. If a GP practice was to take on all aspects of a patient's care it would undoubtedly increase the demand on appointments and the costs to the NHS. There are aspects of care that can be shared with community pharmacy clearly putting aspects into the self-care basket supervised by the pharmacist.

One example may be diabetes. There is little doubt that patients should adopt a routine foot care program in order to reduce hard skin and improve the suppleness of the skin and ultimately to reduce the incidence of infections and ulcers. The GP, however, is only required to deliver an annual footcheck and then follow up care should patients become high risk or actually have signs of complications. Community Pharmacists can target patients with diabetes and offer proactive advice. The GP, practice nurse or podiatrist could ask the patient to visit the pharmacy for routine foot care advice and the sale of an appropriate product.



Another example may be support for patients with asthma. Many community pharmacists already provide inhaler technique support and reinforce the current asthma care plan, however asthma is an atopic condition closely associated with other similar atopic conditions. Pharmacists could take a leading role in the management of hayfever and eczema in these patients relieving the pressure on the GP.

### KEY MESSAGE

***GPs should identify element of holistic care that can be identified as self-care opportunities for delivery within a community pharmacy***

## Redirected Care

It shouldn't mean that if a GP makes a diagnosis in certain conditions the patients' needs to be followed up within the GP practice. The GP should be able to refer the patient to the community pharmacy for follow up care and implementation of a treatment pathway. This might include patients with mild to moderate pain or conditions such as irritable bowel syndrome. The pharmacy would operate under an agreed treatment protocol that supports escalation of treatment and even might include a private PGD to support access to POM medicines.

Many patients present to both community pharmacy and general practice with mild to moderate pain that is treated adequately with simple analgesics and helpful advice. Most of these patients could be adequately managed in the pharmacy, reducing the need for GP appointments until treatment escalation or a further intervention seems likely.

Many patients with IBS feel that their treatment is inadequately managed. Recent discussions estimate that approximately 50% of all GI referrals are for people with functional bowel disorders such as IBS. Many of these patients get in depth investigations that may impact on the hospital's ability to fulfil 2 week cancer commitments. The solution is not to build services within General Practice, but to build services within community pharmacy. This development would change GP perspective from looking to hospital for solutions to looking to community pharmacy.



### KEY MESSAGE

***The GPs should identify situations where, once the diagnosis has been made the complete care of that condition can be transferred to the community pharmacy under an agreed treatment protocol***

## GPs supporting community pharmacy service commissioning

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Community Pharmacy already provide a selection of commissioned services including stop smoking services, emergency hormone contraceptives (EHC) and many others. These provide useful referral points for GPs who can refer patients direct to an alternative service provider. Many GPs have reviewed their practice and now send patients direct to pharmacy rather than delivering the service themselves. There are, however, developments to these services and the development of new services that can reduce the need for GP appointments.

It would seem illogical that a pharmacist with the necessary training to supply EHC to a patient is unable to offer oral contraceptives on an NHS or private service basis. The pharmacist is quite capable of recording a blood pressure and a BMI, asking appropriate questions and tailoring appropriately. The service would be commissioned and run in partnership with General Practice.

There may also be services that the GP practice offer that are not considered to be core and in practice redirect members of the practice staff away from essential core work. It is important that GPs identify these tasks and consider whether they could be provided and/or commissioned within community pharmacy.

### KEY MESSAGE

***GPs have a leading role in the commissioning and development of services from community pharmacy***

## Community Pharmacy and Public Health

The Local Government Association recently produced a report discussing the role of community pharmacy in delivering the Local Authorities public health agenda. Public Health England have acknowledged the important role of community pharmacy as the first contact point for families. However these positive messages have not always translated into commissioned services. Stop smoking and weight reductions services may have the greatest impact on the health of the nation and ultimately NHS costs so must be prioritised.

“Community pharmacies are crucial to any neighbourhood’s local health. They’re often one of the first health points of contact for families, which is why recognising the extent of their importance and understanding their role is key to their involvement in public health. The numerous advice and interventions they offer are able to help people in communities such as their stop smoking services to help people quit and weight management services to promote healthier eating and lifestyles.”

*Kevin Fenton, Director for Health and Wellbeing at Public Health England*

Public Health England. The role of community pharmacies in public health. Available at: <https://www.gov.uk/government/news/the-role-of-community-pharmacies-in-public-health> Date accessed June 2016

### KEY MESSAGE

***Directors of Public Health, CCG commissioning leads, GPs and Community pharmacy representatives should create a local plan to support community pharmacies in delivering a consistent public health message and associated services to their catchment population***

## A Community Pharmacy Forward View

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Healthcare is a complex environment that services a wide range of needs and wants. Healthcare starts at the individual level where people simply have to take better care of themselves and continues through a platform of timely support which involves all sectors of health and social care. Many existing services and new models of care value the input of a pharmacist, but the role of community pharmacy is unexplored and pharmacists in this setting remain the most underutilised healthcare professional in the NHS.

The question is not how to better utilise pharmacists within the NHS, but how the NHS can better utilise the skills of pharmacists within a community pharmacy to reduce demand within primary and secondary care.

The NHS Alliance has started the discussion with this report, but we expect further reports to be generated by community pharmacy organisations and NHS England.

Community pharmacy owners and professional representative bodies such as the Royal Pharmaceutical Society, the National Pharmacy Association and Pharmacy Voice should formally recognise the value of clinical community pharmacy expertise and start to change reward and recognition structures to give greater recognition and reward to community pharmacists who have achieved advanced clinical skills including independent prescriber status.

## Appendix 1

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In 2008 the government published its white paper – Pharmacy in England – Building on strengths, delivering the future. Within this white paper the government made several suggestions to improve the future of community pharmacy in England. These include:

- Expanding the range of medicines available over the counter to treat the conditions that pharmacists can be involved in
- Pharmacies treating more people for common minor ailments (such as coughs, colds, minor stomach and skin problems) on the NHS
- Recommending the use of the NHS LifeCheck service to help people to assess their own health and undertake behaviour change to support a healthier future
- Timely and opportunistic advice on eating a healthy diet, increasing physical activity, weight management and reducing alcohol intake
- Taking on a much more visible and active role in improving the public's health through provision of stop smoking services, sexual health services such as chlamydia screening and access to contraception, including emergency hormonal contraception (EHC), involvement in immunisation services ,including administration of vaccines, and playing a crucial role in influenza pandemic preparation and crisis
- Supporting people with long term conditions (LTCs) (e.g. diabetes or asthma) to improve their quality of life, health and wellbeing and to lead as independent a life as possible by supporting self care
- Supporting better use of medicines – particularly for those newly starting a medicine for an LTC
- Better choice of services, with pharmacists recognised for their clinical skills and contribution, e.g. blood testing and interpretation of results for cholesterol levels, and helping to deliver screening programmes within national and local guidelines following UK National Screening Committee (UK NSC) recommendations
- Advancing patient care by developing the higher-level competencies of consultant pharmacists, pharmacists with special interests, independent and supplementary prescribers or pharmacists registered as defined specialists on the UK Public Health Register
- Close involvement in developing clinical pathways that support integrated care

## Appendix 2

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### **Questions posed in Sustainability and Transformation Plans where the answer should include community pharmacy**

How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?

How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme?

What action will you take to address obesity, including childhood obesity?

How will you achieve a step-change in patient activation and self-care? How will this help you moderate demand and achieve financial balance?

What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure, supported in part through access to national primary care transformation funding?

How rapidly can you implement enhanced access to primary care in evenings and weekends and using technology?

What are your plans to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)?

What is your plan for transforming urgent and emergency care in your area? How will you simplify the current confusing array of entry points? What's your agreed recovery plan to achieve and maintain A&E and ambulance access standards?

What's your plan to maintain the elective care referral to treatment standard? Are you buying sufficient activity, tackling unwarranted variation in demand, proactively offering patient choice of alternatives, and increasing provider productivity?

How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?

How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?

What steps will your local area take to improve dementia services?

As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support?



What plans do you have in place to reduce antimicrobial resistance and ensure responsible prescribing of antibiotics in all care settings? How are you supporting prescribers to enable them issue the right drugs responsibly?

What is your comprehensive and credible plan to moderate demand growth? What are the respective contributions in your local system of: (i) tackling unwarranted variation in care utilisation, e.g. through RightCare; (ii) patient activation and self-care; (iii) new models of care; and (iv) urgent and emergency care reform implementation

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 <https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf>