



NAPC | National Association
of Primary Care



Primary care home: community pharmacy integration and innovation



#primarycarehome

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Foreword

Welcome to this guide on progressing integration of community pharmacy services within the new care model – the primary care home.

Community pharmacy and general practice have traditionally worked closely together. Through the primary care home (PCH) model, the National Association of Primary Care (NAPC) aims to take joint working much further and extend the integration of services and the work of multidisciplinary teams so that community pharmacies are integral to supporting the health and care needs of their local population.

The guide is designed to strengthen relationships between community pharmacy and general practice, and to demonstrate some of the opportunities that exist for greater integration and improved health outcomes.

There are now more than 200* primary care homes across England. As the model continues to spread and becomes a core element of first contact care within integrated care systems (ICSs), we encourage community pharmacists to be part of the change, to strike up conversations about how they can work within a PCH to improve wellbeing, design new integrated pathways and support people with both acute needs and long-term conditions. Over the last few years, there has been talk about collaboration and the untapped potential of community pharmacists to help relieve the strain on the current urgent care system, but there is still much work to be done.

This guide is the work of a forum of clinical leaders within community pharmacy. The NAPC is indebted to the forum and its chair, Michael Lennox, who gave their time advising in a personal capacity.

By tapping into the enthusiasm, potential and expertise of community-based pharmacists to create new solutions to NHS challenges and improve services for their local population, we believe we can make it happen.



Dr James Kingsland OBE
President, NAPC

* 211 sites at the time of publication in May 2018.

1. The landscape of community pharmacy

With around 11,700 community pharmacies across England, the potential for the sector to support the challenges facing the health and care system – including those set out in the NHS Five Year Forward View – has been much reviewed and debated in the last few years.

Pharmacists complete a minimum of five years training and as healthcare professionals are considered a much underused resource. Every day 1.6 million people visit a pharmacy in England and for 89% of people a community pharmacy is within a 20-minute walk.

The 2008 White Paper *Pharmacy in England: building on strengths – delivering the future* heralded a new vision for pharmacy, encouraging the sector to expand and improve the range of clinical services it offers, particularly for those with long-term conditions, including routine monitoring, screening and supporting better use of medicines. It encouraged pharmacies to be centres promoting and supporting healthy living, offering lifestyle advice and self-care support, as well as treating minor ailments.

Since then progress has been relatively slow. This was acknowledged in the Royal Pharmaceutical Society's report *Now or never: shaping pharmacy for the future* in November 2013. In the first report of its Commission on future models of care delivered through pharmacy, it saw the future of pharmacists as having a broader role as 'caregivers' and highlighted they could be integral to the management of long-term conditions, as well as provide an alternative triage point for many common ailments in place of out-of-hours services or accident and emergency departments. As the third largest health profession, it said 'pharmacists have a vital role in helping the NHS make the shift from acute to integrated care'.

The *NHS Five Year Forward View* in 2014 brought pharmacy much more on the agenda for urgent and emergency care – promoting greater use of pharmacists in frontline services. This was followed a few months later by a follow-up report to *Now or never* from the Nuffield Trust commissioned by the Royal Pharmaceutical Society (RPS). It noted there had been traction in 'the care giving role' in urgent and emergency care, and the part it can play in public health, as well as pharmacists working with or within general practices. The area where there was disappointing progress was changing the balance of funding and commissioning from dispensing and supply to the delivery of direct patient services.

The *General Practice Forward View* published in April 2016 described how pharmacists were still 'one of the most underutilised professional resources in the system' and there was a need to 'bring their considerable skills into play more fully'. It promoted the need for pharmacists to be part of the broader practice team and promised a further 1,500 pharmacists to be based in general practice by 2020.



In September 2016, the *Community Pharmacy Forward View* (CPFV) set out the sector's vision of how it could expand and improve its services in response to the challenges. It was published by the Pharmaceutical Services Negotiating Committee (PSNC) and Pharmacy Voice* – with the support of the Royal Pharmaceutical Society's English Pharmacy Board.

Community pharmacy, it stated, had a central role to play and set out three key roles for the sector as the:

- facilitator of personalised care for people with long-term conditions (LTCs)
- trusted, convenient first port of call for episodic healthcare advice and treatment
- neighbourhood health and wellbeing hub.

The report gave an overview of the many ways in which community pharmacy can become an integrated part of the system and provides a useful blueprint for the PCH model. More details of the opportunities for collaborative working with PCHs under these headings are in Chapter 2.

In October 2016, NHS England announced a £42m Pharmacy Integration Fund (PhIF) to be 'the catalyst for innovation' and support community pharmacy to develop new clinical pharmacy services, working practices and digital platforms – particularly integration of community pharmacy into a wider range of primary care settings.

* Pharmacy Voice closed in April 2017.

The two key priorities for 2016/17 were the deployment of pharmacists and pharmacy services in community and primary care, and the development of 'infrastructure' through the pharmacy professional workforce, accelerating digital integration and establishing the principles of medicines optimisation for patient-centred care.

Among the initiatives since it launched have been:

- The NHS Urgent Medicines Supply Advanced Service (NUMSAS)
- Health Education England has been commissioned to produce a workforce plan for pharmacy professionals in primary care
- Deployment of pharmacy professionals in care homes and funding workforce development for pharmacists who work in care homes, including a prescribing qualification
- Funding for pharmacists working in urgent care clinical hubs, such as NHS 111, integrated urgent care clinical hubs or GP out-of-hours services. This includes a prescribing qualification
- Educational grants for community pharmacists to access postgraduate clinical pharmacy education and training courses up to diploma level
- A programme of pharmacy technician clinical leadership development.



Further evidence of the untapped potential of community pharmacy was unveiled in the NHS England commissioned *Community Pharmacy Clinical Services Review* published in December 2016.

Chaired by Richard Murray, from The King's Fund, the review recommended there should be renewed efforts to make the most of the clinical services that community pharmacy can provide and at pace. To impact the health of the population, this should not be as a 'bolt-on' set of services but as an integrated element of patient pathways with the aim of much greater pharmacist support for people with long-term conditions as one part of their care.

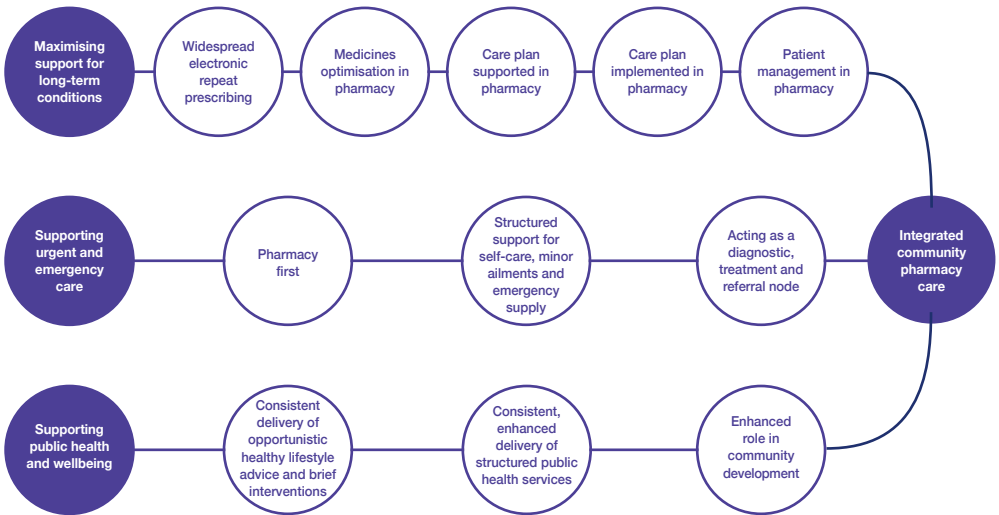
On integrating community pharmacy into new models of care, Richard Murray specifically highlighted:

- the need to integrate community pharmacists and their teams into long-term condition management pathways which implement the principles of medicines optimisation for residents of care homes (including visits to care homes)
- for community pharmacists to be involved in case finding programmes for conditions with significant consequences if not diagnosed, for example, hypertension where they can provide interventions.

In every case, he stressed the need for patient engagement and services built around patient needs. His main recommendation for community pharmacy was that the Medicine Use Reviews (MURs) part of the pharmacy contract should be redesigned to include on-going monitoring and regular follow-up with patients with long-term conditions in care pathways.

To support community pharmacy teams and the roll out of the vision of the CPFV, the sector published *Making it happen* in January 2017 which included a framework for change and set out pathways for three future roles for community pharmacy. It provides a starting point for partnership and discussion between pharmacists and PCHs for new ways of working.

Accelerators for integration



The report outlined six key elements that were needed to deliver the CPFV:

- Raise awareness of community pharmacy services with the public, and strengthen relationships with service users
- Support local leaders to build partnerships with colleagues across the health and care system
- Harness technology and secure digital integration
- Empower the workforce to develop their skills, manage change and work effectively within new structures, cultures and systems
- Establish new ways of working and delivering integrated care, supported through appropriate funding and contracting mechanisms
- Proactively support and facilitate sector development, and change management.



2. Pharmacy work with primary care homes

Community pharmacy and pharmacists are already beginning to play a key role in some primary care homes in England. From supporting patients with long-term conditions like chronic obstructive pulmonary disease (COPD), to preventing ill health through promoting and administering flu vaccinations, they are using their skills to improve the health and wellbeing of their local populations.

Many PCHs are seeing the benefits of having a pharmacist as part of the team – conducting medication reviews, helping reduce unnecessary medications and supporting patients who are taking multiple medications regularly.

In Bedfordshire, Luton Primary Care Cluster PCH has worked with a pharmacist to address polypharmacy in their older population. Polypharmacy – the concurrent use of multiple medications – can lead to an increase in hospital admissions and falls. A three-month pilot targeted people over 75 years taking 10 or more medications. During the pilot, a pharmacist visited surgeries and housebound patients to explain and check their medication in a one-hour consultation.



By the pharmacist reviewing whether they were taking their medication correctly and assessing their risk of developing an adverse drug reaction or admission to hospital, initial analysis suggests there was a significant reduction in the number of GP appointments required by this patient group in the six months afterwards.

Fleetwood PCH directly employs pharmacists who work in their practices and has already rolled out the IT system, EMIS Web, to community pharmacies locally. It is now developing an integrated approach to managing people with long-term conditions including COPD and hypertension. With a COPD rate higher than the national average, it has embarked on a new collaborative project with the local pharmaceutical committee (LPC), clinical commissioning group (CCG) and Boehringer Ingelheim to raise awareness, screen and maximise patient management to improve outcomes. As part of the new approach, community pharmacists will lead a screening programme to identify patients who have not been diagnosed and those at highest risk of developing COPD.

Pharmacists have also been increasing their role in helping support older people as part of the new care model vanguard work in Northumberland. Here an integrated pharmacy team was created to work across primary and secondary care, with the full support of GPs and hospital consultants. The vanguard pharmacy team has access to information across both settings with the vast majority of the work linked to medication queries. It is demonstrating that, where pharmacy is more integrated, it can improve its support to higher risk patients.

Beacon Medical Group PCH worked with its local community pharmacists to help improve local flu vaccination rates. Instead of competing for patients, surgeries and pharmacies worked together, taking advantage of all opportunities to promote the vaccine and recommend the easiest, most appropriate setting for each individual patient. The joint working led to an increase in the number of people taking up the vaccine, including those with respiratory conditions where the rate rose from 39% to 52%. For more information, read the case study on page 38.

NAPC's primary care navigation programme

The NAPC trains frontline staff – including pharmacy assistants, receptionists and administration staff – to actively listen and signpost people to sources of help, advocacy and support. Through the support of care navigators, patients are empowered to manage their personal needs and reduce their reliance on GPs. It is a recommended element of the PCH programme.

The NAPC has trained over 320 members of staff in 150 practices and 60 pharmacies with different programmes tailored to meeting the specific needs of their patients. A case study outlining the NAPC's work with a London GP Federation can be found on page 44.



3. The opportunities for greater collaboration

This chapter suggests ways local pharmaceutical committees and primary care homes can increase integration and make greater use of pharmacists' skills as part of a PCH's whole population health management approach.

There are four key characteristics that underpin a PCH:

- a combined focus on personalisation of care with improvements in population health outcomes
- an integrated workforce, with a strong focus on partnership, spanning primary, secondary and social care
- aligned clinical and financial drivers through a unified, capitated budget with appropriate shared risks and rewards
- provision of care to a defined, registered population of between 30,000 and 50,000.

As part of a PCH, first contact providers come together and work together on a whole population health management approach for the health and wellbeing of their population. To achieve this personalised approach, the population is segmented into groups and a unified team and services are designed around their needs.

i) Building relationships and partnerships

As many of the national reviews have suggested, to realise and untap the potential of community pharmacy and pharmacists, it is imperative that closer relationships are built with other parts of the health and care system.

We are encouraging new or renewed conversations with colleagues in primary care homes, so community pharmacy and PCHs can work together on designing new pathways and integrated services around the needs of their local populations. In the past pharmacy has been regarded as 'insular', an 'outsider' – the development and expansion of the PCH model gives an opportunity for the aspiration of greater integration to happen.

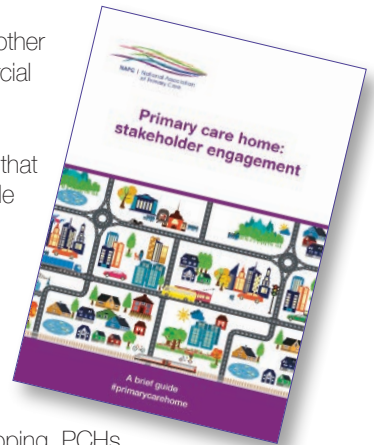
One of the main messages from successful PCHs is that 'things move at the speed of trust' – at the heart of this is strengthening relationships. The key is bringing together the right stakeholders:

- Local PCH leads (latest details of PCHs in your area can be found in the NAPC PCH brochure)
- Local Pharmaceutical Committee (to find your local LPC, visit lpc-online.org.uk)
- Local Medical Committee
- NHS England Pharmacy Local Professional Network Chair
- Sustainability and Transformation Partnership/Integrated Care Service Primary Care Transformation Lead.

This list is not exhaustive – depending on how projects develop, other stakeholders will be involved, for example, project leads, commercial sponsors, local authorities and Public Health England (PHE).

At this stage, funding sources should be considered, to ensure that the relevant colleagues are part of your engagement, for example from STP (Primary Care) Transformation Fund, Health Education England and STP Local Workforce Action Board.

To help with engagement, the NAPC has produced a PCH stakeholder engagement guide which includes information on how to develop an engagement strategy, create a shared vision, design services in partnership with patients and communities along with several tools, including stakeholder mapping. PCHs have access to this on the primary care home workspace at www.future.nhs.uk.



An innovative example of how to foster a collaborative working relationship is Lewisham CCG's 'Walk in my shoes' learning exchange project. GPs and community pharmacists were able to experience life in primary care from a different perspective, and to learn from each other, build relationships and work out solutions together.

GPs visited community pharmacies to gain insight into the community pharmacy working environment and, in return, pharmacists spent time in GP practices. This kind of structured learning exchange enables everyone to understand the areas of frustration, each other's pressures and barriers to success, as well as opportunities for more effective and streamlined ways of working. A programme toolkit is available.¹

1. The Walk in my shoes toolkit can be accessed at <http://psnc.org.uk/wp-content/uploads/2017/06/PSNC-Briefing-041.17-Walk-in-my-Shoes-toolkit.pdf>

Staff, patients and communities should be involved at the early stages of new service design. Co-production models are included in the NAPC stakeholder engagement guide.

One way of helping a patient gain confidence in a new service is to indicate that a practitioner is part of a wider team, by saying, "I am treating you on behalf of x" or "I am part of x practice team". Illustrating the benefits of change to patients is also important. For example, Beacon Medical Group PCH's 'No waiting room' campaign sought to reinforce the benefits to patients of its multidisciplinary urgent care team. The campaign helped patients understand there was a broad range of clinical expertise they could benefit from.

ii) Facilitator of personalised care for people with long-term conditions

Medicines are the most common method of managing long-term conditions (LTCs), so it is important to consider how community pharmacy teams can become integral to supporting and empowering people with LTCs and their carers to manage their own health.

This aligns with the focus of many PCHs on improving the care and management of patients with LTCs through their population health management approach. These patients often have complex requirements, are seen regularly in general practice and have symptoms managed over a long period of time with medication which is central to their treatment plan.

Pharmacists are ideally placed to play a greater role in supporting and monitoring these patients – ensuring the medication remains effective and is being used to its maximum effect.

The CPFV described an enhanced role for community pharmacy teams based around the principles of medicines optimisation, personalised care and support planning, building on the clinical knowledge and procurement skills of pharmacists to promote evidence-based and cost-effective use of medicines.

As pharmacists are usually located in the heart of their communities with the clinical skills to manage medications, they are well placed to be at the forefront of working with patients with conditions which require ongoing care.

Here are examples of innovative and collaborative work which can be replicated in your area.

Chronic obstructive pulmonary disease (COPD) – this is the second largest cause of emergency admission in the UK but it's a condition that can be effectively managed in the community and where pharmacists can impact on outcomes.

One example is the EPIC project in Leeds where community pharmacy had two consultations with 190 high risk COPD patients from 14 GP practices to help improve and manage their condition. Afterwards, 95% felt they had a better understanding of COPD. The project highlights the need for community pharmacists to be considered in COPD pathway redesign. The full case study is on page 36.

The Community Pharmacy Future (CPF) group², which began its work in 2011, has tested two services related to COPD – a support service to help people living with the condition and a case finding service to detect undiagnosed patients.

Thirty-four pharmacies across the Wirral were part of the support service assisting 305 patients either by promoting or providing a smoking cessation service, ensuring medications were being used as effectively as possible and, where appropriate, recommending patients with recurrent chest infections to obtain a rescue pack containing steroids and antibiotics to prevent hospital admission. Following the service, patients reported improvements in taking their medication as well as quality of life. The findings also indicated a reduction in routine GP visits.

The case finding service screened 238 patients over nine months, identifying those who may otherwise have remained undiagnosed and become more acutely unwell. This included offering stop smoking advice, an important intervention for those at risk.

The CPF group is sponsored by the four largest pharmacy companies – Boots UK, LloydsPharmacy, Rowlands Pharmacy and Well – and involves pharmacies from across the sector.

As mentioned on page 9, Fleetwood PCH has begun a new COPD project with the local pharmaceutical committee, CCG and Boehringer Ingelheim to raise awareness, screen and maximise patient management to improve outcomes.

As part of the new approach, the PCH is designing a more patient-centric pathway with community pharmacy teams screening and identifying potential COPD patients and PCH healthcare teams signposting patients to the relevant professionals. The aim is to reduce COPD patients' emergency admissions and reduce GP appointments.

Polypharmacy – the concurrent use of multiple medicines can be associated with ill health and hospital admission. NICE guidance says the benefit gained from each additional medicine is likely to reduce when people take multiple preventative medicines and the risk of harm increases.

Pharmacists have the skills and training to help combat this. In Cornwall, a community pharmacy home visiting service was introduced. Pharmacists had relaxed informal conversations with frail older people in their home to assess patients' understanding of their condition and treatment. An evaluation found that 30% were likely to have avoided hospital admission. The full case study can be read on page 42.



The CPF group also tested a support service for people aged over 65 taking four or more medicines (FOMM). It involved 25 pharmacies in Wigan and 620 patients. Pharmacists held regular consultations with patients to discuss the risk of falls, pain management, adherence and general health. After six months, the findings showed patients had a significant increase in medicines' compliance, a significant reduction in medical and self-treated falls and an increase in their quality of life.

Pharmacy care plans – a second phase of the CPF group work has focused on delivering and evaluating a new pharmacy care plan (PCP) service for 378 patients in West Yorkshire³. The 12-month project involved 38 community pharmacies coaching, signposting and helping people to self-manage their long-term conditions when they collected their prescribed medication. As part of the service, the Patient Activation Measure (PAM[®]) was used to assess the knowledge, skill and confidence a person has in managing their own health and assess whether it improved. The study found that community pharmacy can improve patients' quality of life, increasing levels of patient activation and empowering people to manage their own conditions.

iii) Trusted, convenient first port of call for episodic healthcare advice and treatment

A community pharmacy is often the best place to receive safe advice and treatment for minor ailments, injuries and self-limiting conditions, as well as to obtain regular medicines in an emergency. They are also a valuable way of finding out about other local health and care services.

Asking a community pharmacist for help in these situations is often more convenient than making an appointment with a doctor or practice nurse. It also helps to reduce pressure on general

3. Twigg, M.J., *Research in Social and Administrative Pharmacy* (2018), <https://doi.org/10.1016/j.sapharm.2018.03.062>
Further information: communitypharmacyfuture.org/pages/pharmacy_care_plan_248975.cfm

practice and accident and emergency services enabling them to focus on people with more serious or acute health issues. The ambition for the CPFV is for people and professionals to be in the habit of going to or signposting 'pharmacy first' for non-emergency care.

For this to be a reality, community pharmacy needs to work in partnership with other parts of the health and care system and be integrated with new models of care. Examples have been emerging as part of the development of urgent and emergency care systems.

In Devon, 186 pharmacies have been participating in the 'Pharmacy First' scheme, which provides a minor ailments service (MAS). Patients don't need to make an appointment or visit a GP for a prescription. The service is provided through patient group directions (PGD) which allows pharmacists to supply certain prescription medicines.

Under the scheme, pharmacists offer advice and treatment for a range of minor ailments including coughs, skin rashes and eye infections. In the first 16 months, they had completed more than 17,000 consultations. The service has reduced demand on GP appointments and visits to accident and emergency (A&E).

Another example of moving care to community pharmacy is the NHS Urgent Medicine Supply Advanced Service (NUMSAS). This enables NHS 111 to refer patients to community pharmacy to supply a repeat prescription where the pharmacist identifies there is an immediate need. The service uses NHSmail or IT systems using the Interoperability Toolkit to transfer information about the patient to the pharmacy to enable appropriate care and treatment.

As part of its urgent and emergency care review, NHS England is piloting integrated models of care and interventions that will increasingly 'channel shift' patients to the most appropriate setting including people with minor ailments to community pharmacy. It has developed a Consolidated Channel Shift Model (CCSM) to help commissioners and providers understand what happens when interventions are put in place.

The model sets out 16 intervention models including for community pharmacy a MAS with patient group directions (as described above). A user guide and toolkit for the CCSM is available.⁴

iv) Neighbourhood health and wellbeing hub

Part of the CPFV's vision was for community pharmacies to be neighbourhood health and wellbeing centres – for them to become the 'go to' location for support, advice and resources on staying well and independent.

4. Available at www.england.nhs.uk/urgent-emergency-care/about-uec/euc-channel-shift

What is a healthy living pharmacy?




This builds on the Healthy Living Pharmacy (HLP) framework which was introduced in 2009 to improve the wellbeing of the local community and reduce health inequalities through community pharmacies providing a range of public health services. Since then more than 9,000 pharmacies have been accredited.


Working with their local PCH, community pharmacies can support the needs of the local population by providing access to high quality, personalised support for lifestyle and behaviour change at convenient and flexible times. Services could include stop smoking, blood pressure monitoring, vaccinations, emergency contraception, sexually transmitted infection (STI) screening and advice, healthy eating and weight loss, alcohol brief intervention or advice and NHS Health Checks.

High blood pressure – affects more than one in four adults in England and more than 5.5 million people in England have undiagnosed blood pressure, according to Public Health England (PHE). Described as the ‘silent killer’, it rarely causes symptoms but yet in 2015 was thought to be responsible for 75,000 deaths (Global Burden of Disease report).


In Wakefield in 2014, a PHE campaign, involving local health partners including community pharmacies, encouraged 40 to 75 year olds to have their blood pressure checked at drop-in clinics. It led to 3,632 tests being carried out with three in 10 people tested being referred to their GP. For the full case study, see page 40.


Public Health England
Healthmatters High blood pressure in England

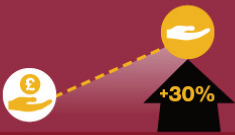
High blood pressure affects **more than 1 in 4** adults in England




High blood pressure is the **3rd biggest risk factor** for premature death and disability in England after smoking and poor diet



People from the most deprived areas in England are **30%** more likely than the least-deprived to have high blood pressure



At least half of all heart attacks and strokes are associated with high BP and it is a major risk factor for chronic kidney disease, heart failure and dementia



Flu vaccinations – More than 70% of over 65 year olds in England had the flu vaccination in 2016/17. There were 107 flu deaths recorded and 953 admissions to an intensive care or high dependency unit.

Beacon Medical Group PCH and local community pharmacies transformed the turf wars style competition over flu vaccinations to promote each other's services. Patients who had previously declined a vaccination were given a prompt on their prescription inviting them again to have a flu jab. Electronic prescriptions sent directly to the pharmacy also included a message to the pharmacist to offer the vaccination. The full case study is on page 38.

4. Workforce

For community pharmacy to realise the aspirations outlined in the Community Pharmacy Forward View, integration and developing a more joined-up workforce is a vital step. This chapter examines why workforce redesign is important and the issues community pharmacy will need to consider to improve the workforce to maximise their role in the community.

Among the key areas are driving a new culture and developing the right skills.

The chapter should be read in conjunction with *Primary Care Home: population health-based workforce redesign* (available on the NAPC website). The guide to workforce redesign outlines a comprehensive model of how to design and deliver workforce change to deliver the aims of a PCH. It also signposts to tools and resources community pharmacy workforce leaders will find useful.

The team

As well as the pharmacist, the community pharmacy team is made up of a range of professionals and support staff. These include the medicines counter assistant (MCA) who is often the first point of contact for patients, the pharmacy assistant who supports the pharmacist dispensing prescriptions and managing stock, the pharmacy technician (see information right) and the accredited checking technician (ACT) who has completed additional training to check the accuracy of the medicines being dispensed. All Healthy Living Pharmacies must also have a Healthy Living Champion (for more information, see page 20).

Pharmacy technicians

Pharmacy technicians play an integral part in the pharmacy team, working under the direction of a registered pharmacist. They prepare medicines and other healthcare products and supply them to patients. They also take an active role in providing patients with guidance on taking medicines. Their training consists of two years consecutive work-based experience.

Driving a new culture

As community pharmacy becomes more closely aligned with other parts of the primary care community, there will be an inevitable need to change behaviours and develop a new culture. Historically, community pharmacies have acted largely independently from the broader healthcare system and in many cases have operated in competition with one and other. To develop a more integrated model, a move towards collaboration and a greater sense of working together will be a priority.



The new environment requires community pharmacy to be an integrated partner, working seamlessly within pathways with other health and care partners. This requires a deeper understanding of the wider health system. Community pharmacists would no longer be competitors in the community but partners working to improve outcomes.

This journey will take some time and needs to begin with greater understanding of what others can do to optimise what everyone has to offer (see earlier reference to the 'Walk in my shoes' learning exchange project in page 12).

There is a need for training with local providers, for joint primary care strategy development sessions and common incentives.

Developing the right skills

As community pharmacies begin to play a more active role in PCHs, staff will be working alongside colleagues in different settings and this multidisciplinary working will require a shift of working practices.

Healthy Living Champions (HLCs)

These are members of the community pharmacy team who are trained and accredited to provide customers with health and well-being advice. Their key role is to provide customers with health information and signpost them to other community services that will help them to adopt healthier lifestyles and access the support they need. Healthy Living Champions have achieved the Royal Society for Public Health Understanding Health Improvement Level 2 award.

Community pharmacy needs to develop a talent bank across the community that can be called on to address changing needs. It will also need flexible and proactive leadership to ensure opportunities for community pharmacy are recognised. It will be key that the competencies available across the pharmacy team are understood and their skills are maximised in PCHs.

To operate outside their usual sphere of experience, pharmacists and support staff will have to build confidence, and increasing skills and clinical peer support will be critical. Development of clinical networks could be key in providing this support.

As the workforce develops and roles change, advanced training will be needed. New areas of development and training need to be considered to make sure the pharmacy workforce has the right clinical skills available to deliver the services needed within the PCH.

To provide assurance and trust in community pharmacists' delivery of clinical care, there are a number of potential areas for training and development. These include independent prescribing, in-depth training on LTCs (diabetes, respiratory, cardiovascular) to support care planning, medicines optimisation and understanding GP systems.

Pharmacist independent prescriber

Pharmacists have been able to prescribe independently since regulations were introduced in 2006. A pharmacist independent prescriber who has training through an accredited programme may prescribe autonomously for any condition within their clinical competence. This excludes three controlled drugs for the treatment of addiction.

As part of the Pharmacy Integration Fund, Health Education England (HEE) has developed a programme of innovative education and training aimed at strengthening and diversifying the pharmacy workforce. This aims to maximise pharmacists' clinical skills working in multi-disciplinary teams (MDTs) as part of new models of care. The programme includes post-registration training for community pharmacists at masters-level until March 2019.

The RPS faculty is a professional recognition and development programme which has a useful platform for encouraging further enhancement of clinical skills through peer learning. The programme will help in creating the clinical platform for the changes that are required. The assessment is more closely aligned to that in medicine and will provide assurance as roles and activities change in settings of care.

E learning platforms are available through the Centre for Pharmacy Postgraduate Education (CPPE) at the University of Manchester. There are also resources and support available for community pharmacy leaders developing their workforce.

Community Education Providers Networks (CEPNs) are becoming increasingly important in developing the education portfolio for primary care. CEPNs have funding streams and drive the delivery of local educational priorities. Other areas of workforce support are available from HEE including Making Every Contact Count (MECC) training, the Pharmacy Integration Fund including independent prescribing qualifications for up to 2,000 pharmacists, sustainability and transformation partnerships (STPs) and through CCG medicine optimisation teams.

New skills, enhanced clinical competence and confidence will be significant contributors in enabling change in working practice.

5. Interoperability

The development of new models of care has brought with it a renewed focus on effective information sharing between organisations, care settings, professionals and patients.

This is dependent on IT across health and care being interoperable – which means systems being able to communicate with each other to ensure real-time information is available for the practitioners involved in a patient's care. This is essential for safety and providing quality care as well as improving the patient's experience.

For PCHs working with community pharmacy, interoperability is key to enabling a collaborative and integrated approach to care. In this chapter, we give an overview of community pharmacy IT progress to date, the future opportunities and highlight some areas PCHs may wish to consider.

Interoperability is about more than the exchange of information. As stated in the *Community Pharmacy Clinical Services Review* (see page 6), unlocking the full potential of community pharmacy requires a step change in the availability of information to inform clinical decision making. It requires greater digital maturity and interconnectivity to allow pharmacy staff to see, document and share clinical information about patient care with the clinical records held by other healthcare professionals and the actions, recommendations and rationale for clinical interventions made by pharmacy professionals to be visible to the wider team.⁵

Learning what is working

Electronic Prescription Service (EPS)

The most obvious example of interoperability in England between GPs and community pharmacists is the Electronic Prescription Service (EPS). This is a system that sends electronic prescriptions from GPs to pharmacies. This has slowly matured into a three-way system with information flowing from GPs to a central database (the Spine) where it is collected by community pharmacies to provide dispensing services to patients. The dispensing information then flows to this database from the pharmacy to show the dispensed status against the prescription. There are plans to enable this information to flow back to the GP, either on request or automatically.

Eventually EPS will remove the need for most paper prescriptions. Plans are being finalised to pilot and roll out Phase 4 of EPS, with electronic prescriptions becoming the default option. To date, it has only been possible to issue an EPS prescription where the patient has nominated a

5. *Community Pharmacy Clinical Services Review*, R.Murray. www.england.nhs.uk/commissioning/wpcontent/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf



pharmacy or other dispenser. A paper prescription will still be used when a patient explicitly asks their GP for one, or when the medicine being prescribed is not listed in the NHS list of medicines.

EPS has most benefited patients who receive regular medications and who tend to get their prescriptions dispensed at the same pharmacy most of the time.

Electronic Repeat Dispensing (eRD)

Repeat dispensing is an essential service within the Community Pharmacy Contractual Framework (CPCF). This enables pharmacy teams to dispense repeat prescriptions issued by a GP, to ensure that each repeat supply is needed, and to check that there isn't any reason why the patient should be referred back to their GP.

Originally this service operated via paper prescriptions, but as the EPS developed, most repeat dispensing is carried out via EPS and is termed Electronic Repeat Dispensing (eRD). This is more efficient and convenient for all involved.

NHS Summary Care Record

The NHS Summary Care Record (SCR) was rolled out to community pharmacies in England in 2016 and 2017. Pharmacists and pharmacy technicians who have been trained in SCR usage can have key clinical information (including medicines, allergies and adverse reactions) about a patient, with their consent.

Over 95% of pharmacists in England have access to SCR.⁶ There is work to make access easier by integrating SCR information into community pharmacy IT systems.

When a patient consents to including additional information in their SCR, a GP can add it by changing the consent status on the clinical system. This means more information will be available to health and care staff, including community pharmacists and pharmacy technicians, viewing the SCR. It will be automatically updated when the GP record is revised.

It is useful for people with complex or long-term conditions, or patients reaching end of life. More information is available on the NHS Digital website.



6. www.england.nhs.uk/wp-content/uploads/2018/03/quality-pharmacy-scheme-infographic-april-nov-2017.pdf

NHSmal

For several years, community pharmacies in England have been able to request access to a shared NHSmal account which allows them to send confidential patient data securely between healthcare providers. As of 2017, 95% of pharmacies in England can send and receive NHSmal.⁷

In the future, community pharmacy staff may be able to 'instant message' other NHSmal users via Skype for Business, for free, as part of the core NHSmal service. For example, this could allow community pharmacy staff to communicate or instant message with other community pharmacies, GP practice staff or care home staff.

Flu vaccinations

By far the biggest flow of information in recent years from community pharmacy to general practices has been the reporting of flu vaccinations over the winter period. It is recognised that paper reporting this information is slow and onerous for GP practices, requiring scanning and storage.

Transmitting the information through secure nhs.net email is an improvement as it doesn't require scanning, but it still needs GP practice staff to place the information in a patient's record. The next stage of IT development, supported by NHS Digital, will allow information from community pharmacies such as flu vaccination to be directly inserted into a patient's record.

Where the future lies

National Information Board

There is a significant amount of work being carried out by the National Information Board (NIB) – a partnership overseeing national IT programmes, NHS Digital and clinical system suppliers to design a new system for the delivery of clinical data.

PCHs can use the information available about this work to help shape their planning and solutions, and to ensure that, where possible, they have longevity.

NIB outlined three drivers for their Integrating Pharmacy Across Care Settings programme which are relevant to PCHs:

1. Viewing patient records
2. Activity reporting
3. Referrals

7. www.england.nhs.uk/wp-content/uploads/2018/03/quality-pharmacy-scheme-infographic-april-nov-2017.pdf

Tactical solutions

For the three drivers, there are solutions available for PCHs:

1. Viewing patient records

This is the ability for one system to communicate with another, with appropriate information governance and data-sharing controls in place, together with explicit patient consent. This is in development through the GP Connect programme. This will allow community pharmacy to provide long-term condition care to patients without the need to share clinical systems directly.

For pilots, it is likely that GP practices and community pharmacies will be working together as teams. Many localities have settled on the same clinical system across multiple practices, either because the CCG has requested it or because practitioners have been using it.

For systems using secure cloud storage, the solution is a relatively simple one of extending software licences to the community pharmacies where joint work on patient care is taking place. Most pharmacies are connected via N3 or the Health and Social Care Network (HSCN) – a data network for health and care organisations – and appropriate contractual and role-based controls, and governance can be implemented quickly and easily.

In Sheffield, for example, collaboration between Jaunty Springs Health



Centre and a community pharmacy is being delivered using a laptop in the pharmacy that has a connection to the GP practice system via a smart card and the existing pharmacy N3 connection. The community pharmacy has read/write access to the system and is able to update patient records in real time after consultations. The collaborative work is underpinned by a data sharing agreement between the community pharmacy and GP practice.

For systems using practice-based servers or desktop systems, there would need to be either a direct network connection (suitable for co-located premises) or the use of a secure virtual private network (VPN) between the two premises. Both of these solutions would enable appropriate read and write access to the records directly. Other solutions which enable either activity reporting or referral requests would not require direct access to write to patient records and should be deployable without additional resources.

2. Activity reporting

Reporting should encompass work such as observations and measurements to allow the GP clinical record to provide the most complete view of a patient's health and wellbeing. There are three areas of activity reporting:

- **The report content**

Some GP clinical systems have mechanisms to handle the content appropriately, with various levels of clinical coding and manual intervention required. The general rule is the more modern the report content design, the better the coding and reduced intervention. Implementation of Systemised Nomenclature of Medicine – Clinical Terms (SNOMED CT) coding across all clinical systems was introduced on 1 April 2018.

- **The means of delivery**

Often, how a report is received is closely linked to the content of the report. Mechanisms exist to transport patient and clinician information appropriately and there are regular new developments in this area. PCHs should explore with both GP system and pharmacy system suppliers what is available locally. For example, MESH (previously DTS) mailbox access, Docman or commercial systems may be appropriate. Specific data-sharing agreements between parties meeting the requirements of the NHS Information Governance Toolkit to at least Level 2 are not required.

- **The systems in place**

It is important that interoperability meets the operational and clinical needs of everyone, as well as fitting in with time constraints. Working with a system that meets the team's needs is more desirable than having three or four systems requiring separate login details and trying to coordinate between them manually. PCH leaders should examine which systems are in place and those that are critical for success.

3. Referrals

Where a community pharmacy has reason to refer a patient to their GP, for example where a clinical observation has fallen outside of an agreed care management plan, the request should appear in the workflow of the appropriate clinical system for review, reaction or action by the practice.

The use of nhs.net secure email can contribute to workflows in GP practice systems until a complete solution is available. There have been a number of projects to introduce GP workflows on both SystmOne and EMIS systems.

Examples of good practice

Local projects to support interoperability between community pharmacies and other health and care providers which PCHs may wish to consider are listed below.

- **Hospital discharge and medicines reconciliation**

Clinical handover from hospital to primary care remains reliant on human intervention even with digital transfer, according to an audit report in August 2016.⁸ A medicines reconciliation process (a way of ensuring that a patient's medication list is up-to-date) on discharge when the next prescription issued by the patient's practice is dispensed reduces the risk of re-admission,⁹ providing both patient and cost benefits (£1,609 per avoided admission and £306 per avoided bed day¹⁰). When an electronic referral system between hospital and community pharmacies across the North East of England was implemented, annual savings for 10 of the highest risk patients discharged each day, who were referred for medicines reconciliation to community pharmacy, was £1.36m.



8. www.sps.nhs.uk/wp-content/uploads/2015/11/Medicines_Reconciliation_Collaborative_Audit_Report.pdf

9. Nazar et al. bmjopen.bmj.com/content/bmjopen/6/10/e012532.full.pdf

10. Reference Costs for NHS Services, 2015/16, www.gov.uk/government/publications/nhs-reference-costs-2015-to-2016

- **Pharmacists in the Wirral reporting via Docman**

Community pharmacies in the Wirral are providing triage, clinical care to patients and recording their interventions on a clinical system. The system passes on the information directly to the Docman Managed Hub to populate GP clinical records. Within the practices, absorbing the pharmacy record to populate the patient journal forms part of the regular workflow without the need to re-code or re-key any information.

- **Data sharing in Sheffield**

See page 26 for information on data sharing in Sheffield.

Other areas for PCH consideration

PCHs can use the information in this chapter to help shape their planning and development of IT solutions, and ensure that, where possible, they have longevity and interoperability between IT systems.

To enable interoperability with community pharmacy, use this checklist:

- Consider interoperability between existing GP and pharmacy systems and how this can be optimised
 - Explore with both GP system and pharmacy system suppliers what is available locally and whether data sharing agreements are in place and if they are required
 - Optimise the use of EPS and eRD
 - Consider extending the information on the SCR to provide community pharmacy and other professionals with enhanced SCR access
 - Promote greater use of NHSmail to communicate between PCH organisations
 - Consider local schemes to enable read/write access to electronic patient records
 - Consider interoperability in plans or pathways to ensure alignment with regional and national plans.
-

6. Contracting with community pharmacy

Community pharmacists provide NHS pharmaceutical services under the community pharmacy contractual framework (CPCF). This chapter gives a briefing for PCHs on the current contracting arrangements.

The CPCF consists of three service levels:

- **Essential services** and clinical governance which are provided by all pharmacy contractors and commissioned by NHS England
- **Advanced services** which can be provided by all contractors, once accreditation requirements have been met, and are commissioned by NHS England
- **Locally commissioned services** are services commissioned by local authorities, CCGs and NHS England.



Pharmacy owners must provide essential services, but they can choose whether to provide advanced and locally commissioned services.

Essential services

Community pharmacies receive a single activity fee for every item dispensed. It covers the majority of the payment that contractors receive for essential services, such as dispensing medicines and appliances, disposing of unwanted medicines, advising on self-care and promoting healthy lifestyles.

Advanced services

There are six advanced services within the contractual framework:

- Medicines Use Reviews (MURs) – for patients, especially those with long-term conditions, taking multiple medicines
-

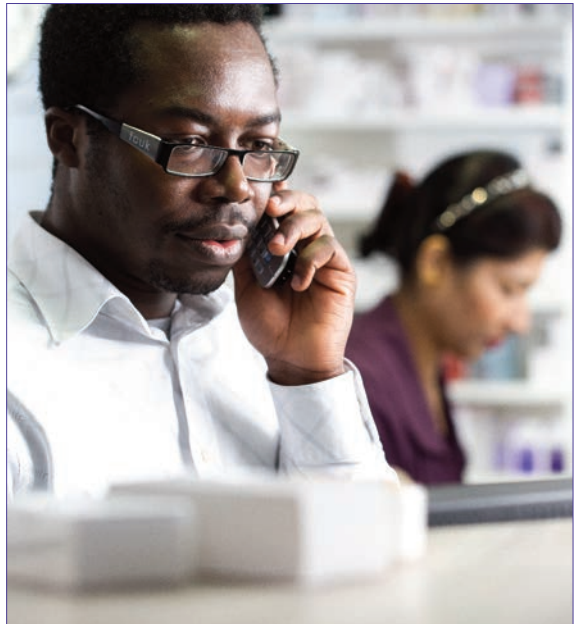
- New Medicine Service (NMS) – to help improve medicine adherence among people with long-term conditions who have been prescribed new medication
- Appliance Use Reviews (AUR) – to support patients in the use, safe storage and disposal of appliances
- Stoma Appliance Customisation (SAC) – to ensure the proper use and comfortable fitting of the stoma appliance and to improve the duration of use to reduce waste
- NHS Urgent Medicine Supply Advanced Service (NUMSAS) – in an emergency, pharmacists can provide previously prescribed medicines via referral from NHS 111
- Flu vaccinations – pharmacists offer a seasonal flu vaccination service for patients in at-risk groups.

Locally commissioned services

Examples of locally commissioned services include alcohol screening and support, minor ailment services and stop smoking schemes, emergency hormonal contraception and weight management.

Potential future contracting with community pharmacy

Effective contracting with community pharmacy will enable PCHs to maximise the potential of the community pharmacy network. Historically, in some areas, service contracts for community pharmacy and other areas of primary care have led to tension and perceived conflicts of interest. Innovative new contracting methods will ensure that all elements of primary care are working together to deliver the best and safest care for the local community in the most cost-effective manner.





Local pharmaceutical services contracts

Local pharmaceutical services (LPS) contracts provide commissioners with the flexibility to include, within a single local contract, a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under the contractual framework. LPS contracts must include a dispensing service, but they do enable the tailoring of community pharmacy services to meet specific local needs. All services currently provided through national arrangements may also be commissioned through LPS contracts as well as services not traditionally associated with pharmacy.

Other possible local contracting options

Contracting bundles of care – for example bundled sexual health services such as emergency hormonal contraception, initiating contraception, referral for long-acting reversible contraception (LARC), chlamydia tests and treatment and testing for other sexually transmitted infections.

Prime contractors – a single contractor or pharmacy is contracted to deliver care for a population. The delivery of this contract is then sub-contracted to other suitable providers. This approach reduces the administrative burden on the commissioner of contracting with many different providers. One example of this could be a service commissioned to a local pharmacy provider company, that local pharmacies are members of, which would take on the management of the contract.

Alliance contracting – an alliance may be in the form of an informal joint venture or consortia without the need for a new legal entity to be created. There is still a single point of contact for the commissioner within the alliance leadership team. The commissioner can be a part of the alliance, sharing both the risks and rewards so that all parties succeed or fail together. Alliance contracts tend to be more outcomes based as objectives are aligned for all parties and everyone signs up to an agreed vision and values against which the contract will be delivered.

Bonus/top up payment – if population-based targets are achieved, a bonus pot could be divided among all providers according to the level of service delivered.

Split payment – separate payments are made for the initiation and completion of a service and for the achievement of agreed outcomes.

Contracting professional services

– community pharmacists could provide the professional resource required by general practices to carry out the role of a practice-based pharmacist, either co-located within the practice or at the pharmacy. This would be a flexible arrangement, reducing the administrative burden on the PCH.



Conclusion and next steps

There are already some excellent examples of where pharmacists and community pharmacy are working with first contact care and the primary care home model. But their widespread adoption and the continued exploration of innovative ways of working to improve local population health could make a far bigger impact, supporting and empowering patients to self manage their conditions as well as easing pressure on GPs and the wider health system.

Action one: Start the conversation – leaders of primary care homes and LPCs should reach out to each other and forge a new partnership to ensure community pharmacy teams are part of the development and discussion of the PCH population health approach.

Action two: Adopt 'Walk in my shoes' – both sectors can gain an insight into each other's environment through this structured learning exchange toolkit, forging strong relationships and trust.

Action three: Use the NAPC's stakeholder engagement guide – develop a joint engagement strategy and co-design new services with patients and communities.

Action four: Align population health needs with the potential for pharmacy in the three highlighted areas (facilitator of personalised care for people with long-term conditions, trusted, convenient first port of call for episodic healthcare advice, and treatment and neighbourhood health and wellbeing hub).

Action five: Workforce redesign and a culture of greater integration – explore the community pharmacy workforce needs in conjunction with Primary Care Home: population health-based workforce redesign (available on the NAPC website).

We hope this paper has inspired you to look at the opportunities and benefits from progressing integration. All the PCHs are listed in a brochure on the NAPC website, this is continually being updated so please check regularly. A list of the LPCs can be found at lpc-online.org.uk.

For further advice, contact the PCH team at pch@nipc.co.uk.





Case study

Improving outcomes for COPD patients in West Yorkshire

The challenge

Chronic obstructive pulmonary disease (COPD) is the second largest cause of emergency admission in the UK, accounting for one in eight (13,000) emergency admissions to hospital. However, evidence suggests that it is a condition which can be effectively managed in the community where community pharmacists have the opportunity to make an impact on outcomes.

In 2015 Leeds West CCG commissioned the EPIC project (Enabling Patient health Improvements through COPD medicines optimisation) which saw community pharmacists work with patients to improve their ability to manage their own condition. This was achieved through enhancing their understanding of COPD and its management, increasing the self-care element of their treatment and working with them to ensure that they were able to use their COPD medication effectively and correctly.

It targeted high-risk COPD patients at 14 practices in Pudsey, Armley and Bramley within the Leeds West CCG area over a period of four months. The practices were chosen as they were located in areas where COPD patients have high rates of hospital admissions and A&E attendances.

What they did

Community pharmacy teams conducted structured consultations with patients with COPD in the pharmacy setting. Each patient had two consultations, eight weeks apart, with a trained pharmacist or pharmacy technician. The consultations included discussion and advice around smoking cessation, an assessment of their inhaler technique and being taught the most effective way to use it, and an explanation of the medicines they were taking and monitoring of their COPD. Patients were also given lifestyle advice and information on self-care and guidance on what to do about a sudden worsening of their symptoms.



“

Often new services have to be provided by pharmacists so it was really nice that technicians could deliver this and it benefited the rest of the team as well.

”

Lyndsey Leister, pharmacy technician at Well Pharmacy in ArMLEY

The impact

Over four months, 190 COPD patients were seen by community pharmacists and included in the project. The feedback from patients was positive and they reported learning more about their condition and treatment as a result. 95% of patients felt they had a better understanding of COPD following the consultations, and 96% of patients felt they understood their different medicines.

Pharmacists also found that 26% of inhaler devices were not being used properly which dropped to just 3% after patients had been seen by the programme. Overall, there was also a reduction in the CAT (COPD assessment test) score for patients who had taken part in the project when they were assessed 8-12 weeks afterwards. The measure assesses the impact of COPD on a patient's wellbeing and daily life.

Lessons learnt/success factors

The project demonstrated that a COPD consultation within a community pharmacy setting can improve COPD health status and improve a patient's ability to use their inhalers effectively as well as highlight other interventions that may be needed. It suggests that the input of community pharmacy professionals should be considered in COPD pathway redesign.

“

All the feedback from patients was very positive. It was one of the best services we have done, because it really made a difference to patients.

”

Lyndsey Leister, pharmacy technician at Well Pharmacy in ArMLEY





Case study

Flu vaccinations in Devon From turf wars to collaboration

The challenge

Beacon Medical Group primary care home and six community pharmacies felt they needed to work more collaboratively to achieve better outcomes for patients. A key concern was the take-up of flu vaccinations, particularly among high risk and hard to reach groups. Historically, the payment for flu vaccinations had led to competition between pharmacists and GPs. A new way of working was needed to improve both vaccination rates and the relationship.

What they did

Ahead of the 2016/2017 flu season, a project group including community pharmacy, Beacon Medical Group PCH and the Local Pharmaceutical Committee was set up to design a collaborative model and a joint plan for the vaccination programme.

The team decided that the best approach to increase vaccination rates was to build reciprocal links between GPs and pharmacists so that patients could receive a flu jab in the setting that was most appropriate for them. The providers would promote each other's vaccination offer, depending on the needs of the patient. This was a big shift from the previous working practices, which often saw providers competing to achieve the highest number of vaccinations.

Patients who had previously declined a vaccination were given a prompt on their prescription inviting them again. Electronic prescriptions sent directly to the pharmacy also included a message to the pharmacist to offer the flu jab. Patients were offered the vaccination either at the pharmacy or back at the practice.

A local media campaign promoted the idea that people could have the flu jab in a range of settings. The promotion focused on the community-based vaccination clinics in accessible town centre venues including libraries.

The PCH and pharmacies also ran a joint poster campaign across the community – a key



“

This project was about working together as a care community to achieve better outcomes for our community, and success for pharmacies and GP practices.

”

Jonathan Cope, GP, Beacon Medical Group PCH

message was that the more people in the community who had the flu vaccination, the less likely it was that flu would take hold. The aim was to develop a community movement around flu prevention and the potential threats to health associated with the virus.

The campaign was supported by a thermometer graphic across primary care and pharmacy showing progress made towards the joint target set and enabling the community to share in the efforts and successes of the programme.

The impact

Take up of the vaccination in those with respiratory conditions jumped from 39% to 52%, in the carers group it rose from 26% to 33%, and in the 16 to 65-year-old age group, vaccination rates increased from 37% to 47%.

The project fostered a closer working relationship between GPs and community pharmacy, with a more coordinated campaign to achieve better outcomes for patients. They agreed that working together rather than competing was in both their interests and key to financial sustainability.

Lessons learnt/success factors

Lessons learnt included the need to agree a single dataset for benchmarking, improve engagement with clinical leads to secure buy-in early on in the project. It's important to ensure the patient voice is embedded within the project, for example, by including patients in the project group.

“

Our partnered and coordinated approach is key to building a sustainable future. We achieve far more for patients and providers by working together rather than competing.

”

Claire Oatway, Chief Operating Officer, Beacon Medical Group PCH





Case study

Blood pressure monitoring in Wakefield

The challenge

About one in four adults in England has high blood pressure and it's estimated that more than 5.5 million cases are undiagnosed, according to Public Health England (PHE). High blood pressure is a major risk factor for stroke, heart attack, heart failure, chronic kidney disease and cognitive decline. It's estimated to cause more than one in five heart attacks¹ and 50% of strokes².

What they did

PHE ran a pilot publicity campaign from 1 March to 6 April 2014 to encourage people in Wakefield to have their blood pressure checked. The campaign involved various local health partners, including community pharmacy, and was designed to target people aged 40 to 75, with a particular focus on those with the highest risk of hypertension and least engaged with health services. The aims were to increase early detection of high blood pressure and inspire people to improve their lifestyle. The campaign included local press and radio advertising and other publicity promoting four weeks of mobile drop-in units throughout Wakefield where people could have their blood pressure tested.

A total of 3,632 tests were carried out – 2,019 took place in 49 local pharmacies, 1,421 in inflatable mobile testing 'pods' at busy public places, including supermarkets and two local rugby grounds, and the rest involved ASDA depot staff who had the tests in the workplace. Community Pharmacy West Yorkshire provided training for participating pharmacies. Everyone tested was asked a set of lifestyle questions and, depending on their responses, offered advice and signposted to relevant support services.

To evaluate public awareness of, and engagement with, the campaign, an independent market research agency, was commissioned by PHE's marketing team to conduct pre-stage and post-

1. 2004 INTERHEART study figures for Western Europe

2. Lawes et al. International Society of Hypertension. Global burden of blood pressure related disease 2001



“ The Wakefield Blood Pressure pilot demonstrated how we can make better use of community pharmacy as part of a collaborative approach to tackling a major public health problem. ”

*Ruth Buchan, Chief Executive Officer,
Community Pharmacy West Yorkshire*

stage surveys in Wakefield and the control region of Rotherham and North East Lincolnshire. They interviewed a total of 1,236 adults aged 40 and above. To gather more information about how people became aware of the blood pressure testing, their motivations for attending and their experience of the event, exit interviews were carried out at a selection of the mobile testing stations and at the two participating ASDA depots. Respondents who had participated in an exit interview were contacted again three to six weeks later by telephone to check what they had done after the event, including whether they had been to their GP or taken on board any of the lifestyle advice.

The impact

The research revealed three in 10 people tested were referred to their GP after receiving a high blood pressure reading. One in five was found to have a high blood pressure reading but had not been previously diagnosed. Two thirds of those who took part in an interview afterwards said they wanted to find out more about their health after having the test. Of those who received advice about diet, 62% claimed to have taken action to improve their lifestyle. Most people (95%) who attended their GP following the drop-in test had their blood pressure rechecked and three-quarters of them had some form of clinical follow up. Between 15%³ and 20%⁴ of those who visited their GP after referral were diagnosed with high blood pressure.

Lessons learnt/success factors

Pharmacies were able to test a lot of people and target appropriately but may have missed people who were not already using their services. Mobile testing stations attracted people who might be less engaged with healthcare services, with sporting events attracting high numbers in the target age group. Consideration should be given to capturing people's contact details, so they can be reminded to see their GP.

3. Kantar Public research

4. Data extracted through SystmOne, a clinical system used by 34 of the 40 practices in Wakefield





Case study

Community pharmacy visits keep patients at home

The challenge

Cornwall as a popular retirement destination has a large number of frail older people with complex health needs who are taking multiple medications. These patients rarely leave their home and are unlikely to visit a community pharmacist. There was a growing recognition that community pharmacists could support patients to improve the management of their medications in their home and, ultimately, help to reduce unnecessary GP and hospital visits.

What they did

Cornwall and Isles of Scilly Local Pharmaceutical Committee with Kernow CCG developed the community pharmacy home visiting service known as the Cornwall domiciliary service in 2014. Some of the funding for the service came from the Prime Minister's GP Access Fund (formerly known as the Prime Minister's Challenge Fund).

The service involves community pharmacists visiting frail older patients at home to have informal and relaxed conversations about their condition and how they are managing their medications. The aim is to encourage open and candid conversations with patients in familiar surroundings about their condition and medication.

The pharmacist assesses the patient's understanding of their condition, whether they are taking their treatment, and offers advice around the management of their medicines and the best way to take them. The visit also includes educating patients on spotting signs of deterioration by, for example, looking for signs of bleeding and using self-care technology. Visits usually last about an hour. After the visit an action plan is drawn up and shared with the patient's GP and other members of the healthcare team.



“ Frail older people often aren’t able to get to a community pharmacy which means they may be missing out on important medicines management support. ”

*Phillip Yelling, Chief Officer, Cornwall and Isles of Scilly
Local Pharmaceutical Committee (LPC)*

The impact

Evaluation showed patients who used the service reported feeling more confident about their medicines and how they could seek more support if they needed it. More than 30% were likely to have avoided an unplanned admission to hospital, 60.5% of these were associated with high-risk medicines and 46.5% with analgesics (pain relief medication). The service also achieved prescribing cost savings and a reduction in the numbers of medicines that would have been wasted.

Lessons learnt/success factors

Lessons learnt include developing structured training and development for the community pharmacists doing the visits, particularly around confidence building. It is important to secure buy-in and support from GPs and the wider healthcare community early on in the project and to track and evaluate progress throughout using a project management approach.

“ Community pharmacy home visiting services enable these patients to optimise treatments, feel more confident about taking their medicines and reduce GP and hospitals visits. ”

*Phillip Yelling, Chief Officer, Cornwall and Isles of Scilly
Local Pharmaceutical Committee (LPC)*





Case study

Working together to navigate community support

The challenge

The practices within Quay Health Solutions – a London GP federation – were seeing a high number of people with social problems such as isolation and loneliness. They were often seeking advice on non-medical issues such as housing, benefits and social needs. Many also regularly attended their local community pharmacy with similar concerns.

The federation, which consists of 18 practices, wanted to find a new way of working involving GP practices and community pharmacies to signpost people to more appropriate services in the community and, ultimately, ease pressure on member GP practices.

What they did

In 2016, the federation introduced the Primary Care Navigation Programme in partnership with the National Association of Primary Care (NAPC). The aim of the pilot was to train staff at the practices and community pharmacies to actively listen and signpost people with non-medical needs to services in the community.

The first phase of the programme trained 30 frontline staff from 13 practices and eight pharmacies including practice receptionists, healthcare assistants and pharmacy counter staff. The training included e-learning, toolkits, a one-day training course and interactive workshops focused on building relationships and exchanging ideas across sites.

The trained staff, known as primary care navigators (PCNs), work in various ways – at the practice desks and pharmacy counters, via booked appointments in consultation rooms, supporting people in their own home and over the telephone.

Networking with social and community organisations has enabled the PCNs to access a wealth of local resources which they had been previously unaware of. They work alongside Lewisham and Southwark Age UK's Safe and Independent Living (SAIL) navigators and Alzheimer's Society dementia navigators to ensure they are signposting people with more complex needs to the right services.



“ It’s so lovely to have a surgery where you can come in and speak to the receptionists about any of the problems you’re going through. They make you feel so welcome and they’re not too busy to actually listen. ”

*Yvonne Stoute, patient, Old Kent Road Surgery,
Quay Health Solutions*

Since the launch of the pilot, the programme has been made available to the federation's 18 members and has trained 74 staff to become PCNs.

The impact

The programme has had a positive impact on patients and has helped to reduce demand on GP practices. For example, one of the federation's member practices, Old Kent Road Surgery, was able to free up at least 193 appointments (equivalent to over 32 hours) in 24 months as a result of the programme. In another example, a patient with mental health problems booked 32 appointments in a year but after seeing a PCN booked five appointments in nine months. Primary care professionals from as far afield as Sheffield have visited to learn about the success of this work.

The programme has also enabled closer working between the practices, pharmacies and other local services, such as Age UK and local community charities Pembroke House, Blackfriars Settlement and Time and Talents, allowing a more coordinated and joint up approach to care.

Lessons learnt/success factors

Developing PCNs' knowledge takes time and is a continuous process. Sharing insight from local organisations and case studies of patient impact helps to bring learning to life. Having two or more PCNs in each site works well so that they can support each other and share ideas.

“ Community pharmacists can add a tremendous amount of value to primary care navigation. We get to know our patients, particularly frequent visitors, who often strike up a conversation whilst waiting for their prescription. We’re able to build rapport and identify those who would benefit from non-medical services in the community. ”

Zahir Harunani, Community Pharmacist, Surdock Chemist



This paper was compiled by a group of clinical leaders within community pharmacy who came together as a working group for this project. The members of the group were:

- **Michael Lennox**, *Chief Officer, Somerset Local Pharmaceutical Committee (Chair)*
- **Dr James Kingsland OBE**, *President, NAPC*
- **Alastair Buxton**, *Director of NHS Services, Pharmaceutical Services Negotiating Committee (PSNC)*
- **David Bearman**, *Chair of the South West Pharmacy Local Professional Network*
- **Rob Darracott**, *Director, McIntosh Health Partners and Former Chief Executive, Pharmacy Voice*
- **Malcolm Harrison**, *Chief Executive, Company Chemists' Association (CCA)*
- **Clare Kerr**, *Head of Healthcare Policy and Strategy, Celesio UK*
- **Ashok Soni OBE**, *President, Royal Pharmaceutical Society*
- **Liz Stafford**, *Former External Relations and Policy Development Manager, Rowlands Pharmacy*
- **Elizabeth Wade**, *Senior Policy Advisor, NHS Improvement and former Director of Policy, Strategy and Communications, Pharmacy Voice*
- **Gary Warner**, *South Central Regional Representative, Pharmaceutical Services Negotiating Committee (PSNC).*

Further information

For more information about primary care home, visit the National Association for Primary Care (NAPC) website: www.napc.co.uk.

For Local Pharmaceutical Committee (LPC) contacts, visit: lpc-online.org.uk.

The PSNC has a guide on community pharmacy for GPs and practice staff available on the PSNC website: bit.ly/2K8UA2b.



NAPC | National Association
of Primary Care

National Association of Primary Care
5th Floor, 20-21 Cavendish Square, London W1G 0RN

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