ROYAL PHARMACEUTICAL SOCIETY

Fuller Stocktake

Royal Pharmaceutical Society Submission

Introduction:

The Royal Pharmaceutical Society is the professional body for pharmacists and pharmacy in Great Britain, representing pharmacists working in all sectors. Pharmacy is the third largest health profession after medicine and nursing, with more than 56,000 pharmacists and 24,000 pharmacy technicians on the General Pharmaceutical Council (GPhC) register.

Pharmacists and pharmacy teams have been on the frontline of COVID-19 and have shown enormous dedication to supporting the nation's health. They will continue to play a crucial role in the success of the COVID-19 and flu vaccination programmes, alongside delivering vital services across primary and secondary care.

Pharmacists and their teams have a lot to offer Integrated Care Systems (ICSs). Pharmacists are experts in medicines, from their development and procurement, right through to supporting patients and the public in the use of medicines. Because of this, pharmacists should be leading on the medicine's optimisation agenda within ICSs, bringing together all those who influence and impact on medicines optimisation along the patient pathway, including patients themselves. We have recently published our recommendations for Integrated Care Systems which also includes a number of case studies.

Community pharmacies are in the communities and support the delivery of primary care. They are a primary care asset that has yet to be used to its full potential, that could be better utilised by multidisciplinary teams to improve patient care. Across primary care pharmacists can help to reduce health inequalities as well as deliver on the prevention agenda.

PCN and Practice pharmacists working in GP practices, care homes and other primary care and community service settings have a significant role in supporting people with their medicines, ensuring value for money and better patient oucomes. They can help to join up secondary and primary care, supporting the safe transfer of patients and medicines between care settings.

We need health and care systems to recognise the place of pharmacists and their teams in supporting people in their health and care journeys and are hopeful that integrated care systems will at last recognise the value pharmacists and their teams can bring in delivering positive patient outcomes.

Whilst we recognise the Fuller Stocktake is focused on the integration of primary care, it is imperative that the interaction with the wider system is also considered. In particular, the interfaces between primary and secondary care as well as the interfaces between primary health and social care. Pharmacists and their teams working across the system can often support people at these interfaces, especially around transfer of medicines and medicines information. Vertical integration across systems will be key to the success of integrated care

Below we go into more detail around how this can be achieved and the enablers that are needed to make it happen.

1. Workforce and Leadership

RPS view:

Leadership: We were pleased to see the announcement that every ICS will have a community pharmacy clinical lead. These pharmacists need to be adequately resourced and supported so they can effectively undertake this role, including being provided with the time to build their local networks and develop their leadership skills. There is also a need for investment to support community pharmacy PCN Leads to work with clinical directors and others in their PCN to improve team working and collaboration to the benefit of patients within primary care. From a Professional Leadership Body perspective we recommend that these individuals are supported to undergo RPS credentialing at a 'consultant-level'. This would provide them with a clear professional development programme within this role and act as an assurance of standardisation of individuals undertaking this role.

It is critical that every ICS has an Executive Level Director of Pharmacy or Chief Pharmacist, in addition to the community pharmacy clinical lead, who will play a key role in developing a system-wide vision for medicines optimisation and supporting workforce planning. This individual will need to be supported to develop system wide pharmacy networks to develop a shared purpose and vision for the profession as well as to work with the wider system to develop a system-wide vision for medicines optimisation, ensuring the safe use of, and best value for, medicines across systems. The strategic plan for medicines and pharmacy, sometimes called the Integrated Pharmacy and Medicines Optimisation (IPMO) transformation plan, will ensure access to medicines, maximising patient outcomes, medicines sustainability and efficiency, while ensuring safe prescribing and best use of medicines.

Medicines are the most common intervention in primary and secondary healthcare[1] and form a key component of all care pathways. The delivery of medicines priorities within an ICS requires close system working to benefit patients and communities. Multi-professional clinical and care leadership will enable excellent patient outcomes from medicines use and the pharmacy workforce. Pharmacists are experts in medicines and their use and should be available at all points in the patient pathway where medicines are procured, prescribed, optimised, dispensed and supplied, as well as being there to support the person taking the medicine. Involving pharmacists and pharmacy teams more in the optimisation of medicines for individuals will lead to better outcomes for patients and better value for the wider system. This needs to link to and be supported by the national work at NHSE/I on the systemisation of medicines optimisation.

There needs to be a strong voice for primary care at system leadership and place-based levels. This must take place through critical leadership roles including pharmacy, clinical directors, teams across Primary Care Networks (PCNs) who build partnerships in neighbourhoods spanning pharmacy, general practice, community and mental health care, social care, dentistry, optometry and the voluntary sector. There is a need to ensure meaningful engagement and inclusive approaches to decision making across ICS and place-based care that impacts on the pharmacy workforce.

EXAMPLE: See Case Study one in RPS Recommendations and Case Studies for Integrated Care Systems

[1] https://www.nice.org.uk/guidance/ng5/chapter/introduction#:~:text=Medicines%20prevent%2C%20treat%20or%20manage,Organization's%20world%20health%20report%202003).

What is needed:

- Director of Pharmacy and Medicines Optimisation or Chief Pharmacist lead at the executive level of an ICS to lead on medicines optimisation (see section below under governance) and be a wider professional lead for pharmacy.
- Pharmacy leads at PCN level to ensure integration of all elements of pharmacy primary care and to deliver the multidisciplinary clinical leadership ambitions of the NHS. This must be accompanied by protected or funded time for provision of the leadership
- Systematic engagement between ICS and PCN leads
- Funded community pharmacy PCN leadership posts
- All pharmacist leadership posts to be encouraged to undergo RPS credentialing to support them in their roles and provide assurance of quality

Pharmacy Workforce: Pharmacists are the third largest healthcare profession in England and can contribute more to health and care within and across systems if they were better integrated and supported into these systems.

Workforce data is critical to workforce planning. To effectively undertake workforce planning you need to collate transparent data around current roles and services which make up the current workforce activity. Data should include workforce establishment, vacancy rates / turnover broken down by grades / roles, sector and geography. These data are required to provide the bigger picture alongside further information such as reasons for leaving roles, age profiles and equality, diversity and inclusion metrics. These data should then be used to inform future workforce models and what workforce will be required to deliver it. This data will be required across the whole ICS and for all the health and social care workforce.

It would also be useful to understand what amount of time the workforce can spend on different aspects of their jobs such as clinical care, leadership / management, education or research. This will be really important to quantify, for example, to current clinical supervision capacity in primary care to support pre-and post-reg pharmacy education reform. It is important that pharmacists in primary care are given time to work across all these domains, and not just focus on the clinical aspects of their role.

ICSs need to understand the health and care needs of their population and then ensure they have the right skill mix and representation, in all parts of the system, to meet those needs and deliver the best population health outcomes.

ICS workforce plans should consider the essential core roles and responsibility that must be delivered across all sectors of pharmacy to ensure a consistent level of service for the public. Investment is needed to train new pharmacy staff and upskill existing members of the team, matching skills to tasks. Career pathways, supported by credentialing, should continue to be developed and adopted to make all roles more attractive and rewarding, allowing all staff to develop and work to the top of their competence and ability. RPS will soon have a full pathway for primary care specialist pharmacists in existence from Post-reg Foundation (including independent prescribing) to Core Advanced to Advanced specialist in primary care and finally to Consutlant (in primary care).This existing career pathway should be adopted to support pharmacist development across all areas of practice.

Healthcare professionals also need to be supported to have the capacity to undertake protected learning time which could cover a range of activities such as:

- Engaging with continuous professional development to keep abreast of innovation and practice
- Undertaking learning and reflection as part of regulatory revalidation
- Undertaking and recording learning activities, including Supervised Learning Events and reflection, as part of RPS post-registration curricula
- Building evidence of their learning in their e-portfolio against RPS post-registration curricula

- Supporting others with their learning, both from pharmacy and the wider MDT, by observing and giving feedback on their practice
- Undertaking educational and practice supervision
- Assessing others' credentialing portfolios

There needs to be equity across professions in the support for protected learning time in order to support staff wellbeing, retention and recruitment into the pharmacy profession. Pharmacists undertaking their career development pathway will also need time and support to develop their leadership/management and research capabilities. In terms of research, ICS's need to consider how they will support individuals to develop research capability and undertake practice-based research,for example, engaging with local universities to develop these research links.

Pharmacists are increasingly working as part of multidisciplinary teams across primary care. Community pharmacy is evolving with the provision of more clinical services and further integration into the NHS and from 2026 all pharmacist graduates will be qualified as independent prescribers. This provides huge opportunities to use these skills within the primary care workforce and this needs to be considered now to enable the upcoming graduates to undertake roles that make full use of their prescribing qualification, The infrastructure around clinical supervision, the access to appropriate support in continuous developing clinical assessment skills, the mentoring capacity, and the opportunity for all pharmacist graduates to actually use their qualification, both in terms of clinical services, and in terms of the senior support that all new starters need to grow in confidence need to be considered and systems and processes put in place to support them, including in the community pharmacy setting.

EXAMPLE: Community Pharmacist Prescribers in Wales.

The vision in Wales is to ensure patients can access an independent prescriber in every community pharmacy in Wales by 2030. This is being supported by government funding. Data from July 2021 showed that during the previous year over 16,000 patient consultations had been undertaken across the community pharmacy network. There was growth in prescribing services for acute conditions, medicines withdrawal and contraception via community pharmacist prescribing services[2].

As local workforce strategies are developed, they need to take into account how they can support and harness the skills of pharmacist independent prescribers in clinical care, including: investment in training, both for new and existing workforce, access to supervisors, protected learning and development time, alignment with commissioning of services to make best use of independent prescribers across care settings, supported by appropriate prescribing budgets in community pharmacy.

Pharmacists working in all care settings need to have recognised structured career pathways so they can visualise and undertake this progression.The role of PCNs pharmacists is a developing field with no clear vision or support structure in place. Support structures that enable senior/experienced pharmacists to support "junior" pharmacists' need to be developed. There is also a need for reassurance to the current PCN workforce that they will remain part of the team even if funding streams are changed.

The role of pharmacists, in all areas of practice, will be even more important as we move towards individualised treatments in the field of gene therapies, advanced therapies and point of care manufacture. Pharmacists, supported by pharmacy technicians, will be central to providing the technical, logistical and governance expertise for these innovative products. Recognition of the

2 https://www.rpharms.com/Portals/0/RPS%20image%20library/Graphics/IP%20Workstream%20Infographic%20V6%20(002)%202.jpg?ver=moUMB54-fIy92QYBTyliEQ%3d%3d

workforce needed, as treatments and technologies advance, should be a key part of the development of ICSs.

ICSs will need to develop a multi-year workforce strategy in partnership with all their partners across all care settings. All elements of the primary care workforce, including pharmacy, will be key to this strategy and must be included in its development.

Pharmacists, like other professionals, should be supported to have a 'one workforce' approach which enables them to work across care settings, particularly in a clinician's early years, but also enables the development of specialists who will work across a patient pathway in the future. This approach is supported by the RPS credentialing model. Funding for the workforce should be attached to the trainee and follow them through the system, and recognise the need to fund supervisors for their time to develop the upcoming workforce.

Pharmacists must have equal access to professional clinical leadership development opportunities and support for talent generation and future pharmacy leadership. This should apply to those who provide services to NHS patients and the public, as well as those directly employed by the NHS. Identification of any future or aspiring leadership programmes should be open to all of the pharmacy workforce.

To support the development of multidisciplinary teams, training across all areas of practice / sectors should be encouraged and potentially incentivised. Pharmacists should be enabled and supported to have portfolio careers, using their skills, knowledge and expertise across systems.

In terms of the primary care workforce, issues have been raised around the responsibility for employment of staff in primary care (federations, ARRS roles etc) and the fact that sometimes primary care staff do not feel part of the team and are not integrated into the local team. The recent King's Fund report[3] showed a lack of shared understanding about the purpose or potential contribution of the ARRS roles, combined with an overall ambiguity about what multidisciplinary working would mean for GPs. It further stated that successful implementation of the scheme requires extensive cultural, organisational and leadership development skills that are not easily accessible to PCNs.

When considering the pharmacy workforce a theme that should also be running throughout is to ensure there is fair and equal access to development and career progression across all backgrounds and abilities. Creating a culture of belonging and ensuring diversity and representation across of all levels has been demonstrated to have a positive impact on the services delivered to patients and the public particularly in reducing health inequalities

EXAMPLE: See Case Study 2 in RPS Recommendations and Case Studies for Integrated Care Systems

[3] https://www.kingsfund.org.uk/publications/integrating-additional-roles-into-primary-care-networks

What is needed:

- Better data collection around the pharmacy workforce to inform workforce plans
- Pharmacy, across all care settings, to be included in workforce plans
- Investment to develop and educate the pharmacy workforce to support them to practise at the top of their license
- Pharmacists to have access to protected learning time in line with other professions
- Develop process and structures to support pharmacist prescribers to practise in all care settings, including clinical supervision Career development plans for pharmacists working in ICSs aligned to the RPS post-registration credentialing model; and the support and supervision to engage with this
- System wide workplans aligned to the levels articulated above, with clear service alignment, job title/description and salary linked to post-reg foundation, advanced, advanced specailist and consultant levels for pharmacists

Mental health and wellbeing: Pharmacists, like many other professions, are suffering from high levels of burnout (89% of WWB survey respondents). Our latest Mental Health and Wellbeing Survey with independent charity Pharmacist Support, published in December 2021, showed that burnout remains a key issue facing the workforce, with 33% of respondents considering leaving their current role and 32% considering leaving the profession. All staff providing services to the NHS, whether directly employed by the NHS or contracted to provide services to the NHS, need to be supported in terms of their mental health and wellbeing. In the past, community pharmacists have not been recognised as part of the wider NHS team / family and it is only through the recognition of the services they provided during the pandemic that they are now included in Workforce Wellbeing support provided at a national level. It is important that pharmacists and their teams have equity of access to occupational health and the 'NHS People Plan' offers.

Like most professionals, pharmacists have been working long hours and under high pressure, particularly during the pandemic. As ICSs develop, they need to recognise the pressure pharmacists are under and ensure that workforce plans include developing the right environments that enable the workforce to flourish. Enablers such as protected learning time, rest breaks, adequate staffing levels, and flexible working all need to be taken into consideration. Support for personal development and clinical supervision will help to develop leaders of the future that understand all the elements of a system. The culture and workplace environment need to be conducive to good mental health and wellbeing of the people who work there.

Equally, pharmacists and their teams in all care settings need to be seen as part of the wider NHS team. Community pharmacy is often seen as periphery to the NHS, and yet has so much to offer. All parts of primary care, and the wider system, need to feel included and like they belong, and have a say, in the development of their ICS.

Abuse of health and care staff by members of the public should never be tolerated. Throughout the pandemic, community pharmacies in particular have seen higher than average levels of abuse. ICSs need to do everything they can to protect their staff from such abuse.

What is needed

- Continue to include pharmacists and their teams in access to nationally funded mental health and wellbeing support including occupational health and support services
- Work with employers and others to ensure workplace environments are conducive to good mental health and wellbeing
- Engaging, providing information to and educating the public to reduce incidents of abuse in health and care settings
- Support for the development of local peer networks, particularly in those areas where individuals may become professionally isolated

2. Physical Access

RPS view:

Physical estate*:* There are over 11,000 community pharmacies in England and this community asset is not currently being used to its full potential. Not only could other members of the primary care multidisciplinary team make use of this primary care estate, but it could be better utilised to provide public health services. The pharmacy environment itself, and the anonymity it offers, could provide a location that is more conducive to discussing health issues and has the ability to reach groups typically seen as 'hard to engage', for whom visiting a GP surgery may be an intimidating experience. Community pharmacy, as a primary care asset, needs to be considered in the wider management of primary care estate.

PCNs do not currently have enough physical estate to support the integration of the ARRS roles and to enable fully functioning multidisciplinary team working. How truly integrated multidisciplinary teams in primary care function needs to be considered when looking at what physical estate is needed to support the services and care they provide. Failure to invest in health infrastructure risks having a further negative impact on the recruitment and retention of primary care staff. Research by the Picker Institute highlights NHS staff views that efficiency, recruitment, communication and job satisfaction, all fundamental issues for the NHS workforce, are importantly affected by the design of their workplaces. Investing in improved infrastructure for the NHS workforce is not only an investment in helping them to deliver to their full potential, but in creating working environments which make staff feel valued.

Over the next few years, the way in which prescriptions are dispensed is likely to change and hub and spoke arrangements are currently being consulted on. There is the potential that new arrangements could release more physical space within the community pharmacy. There is the opportunity to develop more consulting rooms within community pharmacies for the management of low-acuity conditions and provision of more vaccinations. Greater involvement in the management of long term conditions and also potentially providing a host location for PCN pharmacists working across the system.

During the pandemic, vaccination services were taken outside of traditional primary care providers and delivered in a variety of different settings such as religious venues, community venues etc. This model and approach to delivery of services should be further explored and could also have a positive impact on reducing health inequalities by taking services out to those who need them.

What is needed:

- Make better use of all primary care estate including community pharmacies, and ensure it meets the need of integrated multidisciplinary primary care teams
- Ensure all members of the PCN team feel valued by having dedicated and allocated physical space and resources
- Recognise, and make best use of, the accessibility of community pharmacies and support development of the premises to better serve the local population and service needs

Health Inequalities: The national CORE20PLUS5 focuses on the most deprived 20% of the national population alongside 5 main health areas which includes hypertension case finding, early cancer diagnosis, chronic respiratory disease, severe mental illness and maternity. Currently, pharmacy makes significant contributions to these areas through national campaigns focusing on smoking cessation, cancer awareness and prevention and management of cardiovascular disease. It is good to see that services such as hypertension case finding and continuation of hospital intitiated smoking cessations services are part of the community pharmacy contractual framework in England and an early cancer diagnosis and referral pilot is being developed.

Pharmacy teams in community and general practice are well placed to help address health inequalities given they are well established in the community and have a good understanding of the needs and challenges facing local populations. Being able to gain access to the heart of communities is central to being able to address both the causes and consequences of health inequalities in the UK. An extension to the existing role of community pharmacy teams and increased multidisciplinary teams working with PCNs should be considered to support people from underserved communities, such as some minority ethnic groups, people who are homeless or have no permanent address, and those unlikely to access other healthcare services that require making an appointment (e.g., travellers, asylum seekers, etc.). Teams also need to be supported, such as those within pharmacy teams, with the skills to understand and access data to identify the 20%. This is key in ensuring that the right populations are accessed, and services are taken to them.

Community pharmacies help mitigate health inequalities through the provision of a range of public health services, particularly primary disease prevention and management: vaccination and infection prevention; health screening and self-care; healthy lifestyle, diet and weight management; prevention, management and cessation of substance dependence; management of chronic conditions such as cardiovascular and respiratory disease, diabetes, pain; and supporting mental health and wellbeing.

Pharmacists working across all health and care settings have a role to play in addressing health inequalities. It is important that an ICS maps and understand who within their area contributes to addressing health inequalities, including specialists (such as pharmacists who are specialist in mental health, cardiovascular disease or respiratory disease), substance misuse support as well as a whole range of other services and support. System leadership needs to drive change based on data, research and evidence as significant health inequalities are apparent based in locations (place) and engagement with place based pharmacy leaders will be a crucial component to any transformation project.

Community pharmacies are in the heart of communities and they buck the inverse care law with more pharmacies in areas of higher deprivation. Overall, 89.2% of the population is estimated to have access to a community pharmacy within a 20-minute walk. For urban areas, that is 98.3% of the population, for town and fringe, 79.9% of the population, while for rural areas, 18.9% of the population. An estimated 99.8% of people from the most deprived areas live within just a 20-minute

walk of a community pharmacy. For areas of lowest deprivation 90.2% of the population have access to a community pharmacy within 20-minute walk. Over 1.6 million people visit a pharmacy in England every day. The often informal nature of the contact with a pharmacy means that it is possible to provide opportunistic education, advice and support for people at every stage throughout life.

There are fewer GPs in areas of deprivation[4], where high levels of clinical demands are experienced, and this may contribute to health inequalities. There is a great potential for pharmacists and their teams, particularly those working closely with communities (GP/PCN pharmacists, community pharmacists care homes, etc.), to expand their role in this area. Practice pharmacists can work with their colleagues in general practice to help identify those patients who need most, those who need a moderate amount, and those who need least. They can be involved in social prescribing which facilitates greater participation of patients and citizens and support in developing health literacy and improving health and wellbeing. Some examples of how practice teams can support health inequalities can be found at https://www.kingsfund.org.uk/sites/default/files/field/field_document/health-inequalities-general-practice-gp-inquiry-research-paper-mar11.pdf.

Mechanisms to ensure that the distribution of health professionals adequately reflects clinical need should be explored, such as expanding the role of community pharmacists in deprived areas.

What is needed

- Utilise the fact that community pharmacies are in deprived areas to look at different ways of providing services to these populations such as establishing them as health hubs
- Ensure pharmacists have the same opportunities as other professions to gain access to information that enables them to support population health management and approaches
- Ensure national and local priorities for primary care link explicitly to activities which contribute to the reduction in health inequalities. For example introduction to the market of new therapies –areas in the 20% will require additional support to ensure these are equally accessible to their patients.

Public health: There is widespread recognition of the role that pharmacists can play in improving heath. Many community pharmacists and their teams provide a range of public health services which are part of the national contract or are commissioned locally. This includes services such as stop smoking, antimicrobial resistance, substance misuse, sexual health, diet and healthy weight, cardiovascular disease (such as hypertension case finding), mental health and alcohol consumption. More information on the role of community pharmacies in public health can be found here - https://psnc.org.uk/wp-content/uploads/2021/10/Guidance-for-Commissioners-Community-Pharmacies-v1.0.pdf

Pharmacies in primary care need to be seen as the first port of call for people who are seeking advice and support around their mental and physical health. Systems need to be put in place to enable pharmacists and their teams to support the triage of patients and ensure they are seen by the right part of the system. This needs to be supported by education and training of the public which would explain the pressures on the system and help signpost them to the right elements of the system for the care they need. A service such as the NHS Pharmacy First Scotland [5] service should be considered in England, including the ability to supply certain products free of charge, especially to those who live in more deprived areas. This would also help to reduce health inequalities and reduce the number of people making appointments with their GP in order to obtain a prescription for the product when they are exempt from prescription charges

[4] https://www.cam.ac.uk/research/news/worsening-gp-shortages-in-disadvantaged-areas-likely-to-widen-health-inequalities

[5] https://www.nhsinform.scot/campaigns/nhs-pharmacy-first-scotland

EXAMPLE: Pharmacy First and Pharmacy First Plus Scotland

NHS Pharmacy First Scotland allows community pharmacies to give people expert help for treating conditions such as sore throats, earache and cold sores, along with common clinical conditions such as urinary tract infections (UTI's). Pharmacy teams offer advice, treatment or referral to other healthcare teams if required. This service helps people access the right care in the right place, without having to go to their GP practice or local Accident and Emergency Department for non-urgent treatment.

Pharmacy First Plus builds on the Pharmacy First service and is a Pharmacist Independent Prescriber (PIP) led service for patients presenting in the community pharmacy. Its purpose is to provide an easily accessible service for common clinical conditions which are beyond the scope of the standard NHS Pharmacy First Scotland service and ensures the patient receives the most appropriate and expedient care, thereby reducing the pressures on general practice and urgent care colleagues and systems[6].

Community pharmacies need to be seen as one of the 'front doors' to healthcare and more needs to be done to support this. Implementation of national services such as the Community Pharmacist Consultation Service (CPCS) need to be better supported and these types of services must be better integrated into patient pathways. Community pharmacists and their teams are ideally placed to provide these minor ailment services alongside services that support the health and wellbeing of the nation. Systems need to consider the role of community pharmacy as a hub to support access to health improvement support and enable action on the wider determinants of health.

EXAMPLE: Pharmacy Walk in Consultation Service in Cornwall

Since December 2021, community pharmacies across Cornwall have been commissioned to provide a walk in consultation service to members of the public. The service is based on the national Community Pharmacy Consultation Service (CPCS) but eliminates the need for a referral to come from the GP and enables the person to go directly to the pharmacy. Since it started over 1,800 consultation have taken place for minor ailments across 77 community pharmacies. The service is continuing to be funded past the original end date of March 2022. Patient Group Directions have also been put in place to allow the supply of treatments for migaine and vaginal thrush to be made to the person at the pharmacy. Currently a business case if being developed for the ICB to consider.

More information can be found at https://www.cornwalllpc.org/

[6] https://www.communitypharmacy.scot.nhs.uk/nhs-boards/nhs-fife/pharmacy-first-plus/

Pharmacists and their teams working in primary care also play a significant role in administering vaccinations. This has been demonstrated throughout the Covid-19 pandemic with pharmacists and their teams rapidly stepping up to support the national vaccination prgramme. Community pharmacy has been providing flu vaccinations under a nationally commissioned service since September 2015 and administered almost 4.8 million flu vaccinations in 2021/22, 73% more than the 2.8 million vaccines administered last season. Community pharmacy should be considered as part of the delivery of other vaccinations such as childhood immunisations.

What is needed

- Recognise the role of community pharmacists and their teams have in providing public health services and commission these services more widely from community pharmacies
- Establish a National Pharmacy First Service across England including rapid access to antibiotics for appropriate conditions to reduce the AMR burden
- Integrate the commissioning of public health services under the ICP and ensure a consistent and high quality approach across ICS footprints and places

Specialist Care: Specialist care does not always need to be provided in secondary care settings. There are many examples of outreach clinics where specialists come out into the community to deliver services closer to the patient's home. We have examples where consultant pharmacists work with colleagues in primary care to upskill them and deliver enhanced services in primary care.

EXAMPLE: Providing Specialist Pharmacy Support in Primary Care-the Leeds Experience

Since 2018, Leeds Teaching Hospitals NHS Trust (LTHT) has been formally commissioned by NHS Leeds Clinical Commissioning Group (CCG) to provide specialist pharmacy support to Primary Care.

NHS Leeds CCG now directly employs consultant pharmacists for diabetes and older people whilst other consultantpharmacists for anticoagulation/ thrombosis, cardiovascular and respiratory medicine who are employed by LTHT are working part-time in Primary Care. All of these posts have a system-wide remit to improve outcomes for patients

Evaluation of some of these services has shown that this specialist support is highly valued by primary care pharmacy teams,improves their clinical practiceand results in better patient outcomes ultimately supporting people to receive the specialist pharmacy care they require close to home.

If there are enhanced skills within primary care this may negate the need to refer to secondary care for everything. Services will be able to be delilvered by advanced pharmacists in primary care which would normally be undertaken in secondary care.

RPS will soon have specialist practice credentialing available for advanced specialist primary care and also specialist mental health credential.

In addition, being able to provide services, such as covid vaccination, outwith the pharmacy, facilitates higher uptake in the overall population. This model of service provision should also be considered for other types of services.

What is needed

- Collaboration between primary and secondary colleagues be more widespread, and the best way of delivering specialised care discussed. For example using the Discharge Medicines Service to identify and facilitate specific interventions
- Upskill the generalist workforce to provide more holistic care to populations whose needs have historically been seen as more 'specialist', e.g. mental health, learning disabilities etc

3. Non-Physical Access

RPS view:

Shared Care Records and Interoperability: Now that we are moving from an emergency phase to a business-as-usual approach to COVID-19, it's a good time to take stock of lessons learnt during the pandemic about using data well for patient care. A coherent national data strategy is needed in order to realise the benefits of data-driven care for all citizens.

Having access to a single set of information, for all health and care staff as well as patients themselves, via a Shared Care Record (ShCR) is essential to optimising patient care. Progress in this area has been painfully slow and we would like to see the interoperability of records become a high priority for ICSs. We are aware that some localities have developed Local Health and Care records (LHCRs) and have enabled access to these records for a range of healthcare professionals, including pharmacists.This has benefitted patient care.

Pharmacists in all care settings must be able to view and write to the ShCR. A challenge to the implementation of this is the issue of legacy systems and a historical lack of data standards which makes information exchange and interoperability difficult and complex. Currently, quite often the interventions that pharmacists make are recorded in their individual systems but are unable to be shared with the wider healthcare team. This will become even more critical as all pharmacist graduates will be prescribers.

Information needs to be able to be transferred seamlessly across different parts of the system to support patient pathways. This will negate the need for patients to keep repeating information and ensure that there is one ‘true’ record of care. Enabling all health and care providers to be able to write to records ensures that accurate information is recorded at the point of care and negates the need to send information separately and for it to be transcribed into a patient’s record with the associated risk of error.

Many people are now living with multiple long-term conditions, and from a medicine's safety perspective, it is essential to know all of the medicines a person is taking, any reasons for changes to these medicines as well as what conditions they have been diagnosed with in order to improve patient and medicines safety. The ability to see test results will also support clinical decision making across healthcare professions. Patients are often the only ‘constant ‘in their healthcare and currently carry the burden of information sharing between multiple medical teams and organisations The lack of joined up systems poses massive risks for medicines related harm especially in vulnerable older people e.g. 1 in 3 older people will suffer medicines-related harm after care transition. ICSs need to support transfers of care within and across care settings. The current Discharge Medicines Service goes some way to addressing the medicines issues when patients are transferred from secondary to primary care, but more needs to be done to expand and support this service. The move to Consolidated Medicines Records that pull prescribing history from multiple sources is welcomed, so at

the point of care all information is visible e.g. clozapine, methadone, homecare, chemo, out-patient only medicines etc.

ICS digital leads should develop digital pathways between NHS Trusts, community pharmacy and primary care adopting national interoperability standards such as the dictionary of medicines and devices (dm+d) and structured dose syntax. Having national clinical standards that enable and support interoperability between systems will be key to delivering in this area.

It is also essential that people can be electronically referred from one care provider to another. This is currently enabled in terms of some primary care providers being able to refer patients into secondary care but many parts of the system are unable to do this. The ability to refer a patient from primary to secondary care or between different primary care providers, including social care, is vital for an integrated care system to work. When people present at a community pharmacy with symptoms that require referral, the pharmacist has few options other than the traditional route of informally referring individuals to their GP. The pharmacist may have already recognised that the patient would benefit from quick access to another health or social care professional (e.g. dietician, physiotherapist) but this would currently require onward referral from the GP. Sytems need to be put in place at national or ICS level that enable all health and care providers to make direct onward referrals, within their competencies.

Having full access to information to support care is going to be critical to pharmacists as the profession moves towards increased clinical service delivery. The ability to share information about services provided as well as access to full information to target appropriate care and support is key. In addition, bringing patients closer to their data also means opening up opportunities in the medicines space to provide additional support and guidance, whether this is in the form of apps that support medication reminders or more sophisticated tools that highlight when patients are non-compliant or miss doses leading to poor outcomes.

What is needed:

- An integrated Shared Care Record that all health and care professionals and individual patients have read and write access to in order to provide optimum outcomes for patients.
- Systems need to be able to support the transfer of care, including information about medicines, as people move between different settings and care providers
- Allow for two-way communication and for people to be referred from one provider to another.
- Enable access to budgets for pharmacist prescribers in the community
- Encourage and support full implementation of the Discharge Medicines Service

Data collection and data driven care: Consideration also needs to be given to the data collection burden. Data should only be collected if the use of the data has been defined and it has a purpose. Pharmacists, like many healthcare professionals, are being put under a lot of pressure to provide information some of which could be 'passively' collected, particularly so as pharmacy becomes better integrated into systems and is recognised as part of the frontline clinical delivery team.

Population health data across an area can be analysed to determine the services and support needed for the population on that area. Analysis can help to determine what can potentially be put in place to prevent certain outcomes, for example, if the population in an area has a higher than normal rate of CVD, this could be linked to smoking so smoking cessation services could be commissioned. Where community pharmacy sits within the ICS means it is in a good position to support the collection of population health data that would benefit the overall system. People accessing community pharmacies are not always particularly unwell as they may be accessing for health and wellbeing advice or a minor ailment. Data on these interactions is not currently captured or shared with the

wider system. This would help to build the bigger picture around the health of a local population and also capture public health interventions.

It is essential that data is collected across the system and not just from one part, such as GP practices or hospitals, as this only demonstrates a particular element of care. Data can provide opportunities to benchmark and to see if quality improvement initiatives, when implemented, have an impact on the system and patient care. Data can also be used to develop AI that can support the delivery of care and assist health and social care professionals in undertaking their practice. Over time, data analysis can help to predict the expected outcomes from a particular intervention or set of interventions. It also enables earlier interventions to be made, thereby preventing more complex interventions at a later stage.

Data can really help with exposing health inequalities, for example drilling down into population health management data to identify people living with frailty and then providing different interventions for different local populations. There is also a potential significant problem with digital exclusion, for example some older people, those with cognitive impairment, people from deprived areas and this also needs to be addressed as part of the ICS strategy.

The ability to use data from multiple sources will help to stratify populations, aid decision making, direct interventions and resources e.g. to reduce inequalities

It is also essential that data collected is used to support workforce planning across the health and social care workforce. If you know the local population and their needs then this can be used to help distribute the workforce across the system.

Systems need to demonstrate that data sharing improves outcomes and safety for patients. This will empower patients and the public to trust the system and facilitate better sharing of data and information.

What is needed:

- Recognition of the different parts of the system where useful data may be collected and held and ensuring this data is integrated into the wider system
- Using data to support the analysis of the local population's health and to ascertain what services are needed to support them
- Public trust in systems to reassure them that their data is being shared securely
- Investment in population health management skills and capacity, across the workforce, to ensure interventions are appropriate, effective and targeted at the right population

Workforce training: As technology continues to advance, all of the workforce need to be supported and trained to ensure optimal use of digital technology. The first priority around understanding data to support data-driven innovation is a current failing in our healthcare system. When trying to deliver digital innovation in the workplace, healthcare staff are often unclear as to what and how to interrogate digital systems to get the data they need for innovation. Work is needed to provide staff with an understanding of interpretation and interrogation of data, and visions of how data can change the future of healthcare.

Analytical skills are another area that needs further consideration. The government needs to think about how it will support existing practitioners to upskill with the necessary analytical skills to make sense of the big data that is being collected.

What is needed:

- Training and upskilling of the workforce in digital literacy and use of new and innovative technology relevant to their roles

Technology use now and in the future: Being able to work remotely has been key for some health and care staff during the pandemic. Having ready access to data could facilitate more remote working for health and care staff where appropriate as well as enable more informed remote consultations.

It is important that digital technology is used to support health and care professionals to deliver optimum care for patients and not seen as a replacement to staff. A key area of development during the pandemic was the use of technology to enable consultations with patients to be undertaken remotely. Whilst this type of consultation is not suitable for everyone it provides a different route to advice and support for those who are able and want to use it.

Multidisciplinary teams are also coming together remotely in the use of virtual wards. As experts in medicines and their use, it is essential that pharmacists are included as part of the virtual ward team.

Personalised care will be the way of the future, where patients' treatments are more individualised to provide better outcomes. A recent pharmacogenomics report[7] recommends that every ICS creates an infrastructure for a pharmacogenomics service. Pharmacy teams across the whole system have a vital role to play in pharmacogenomics, particularly in primary care where most prescribing and dispensing takes place for patients. Pharmacists have a critical leadership role in the multidisciplinary team for pharmacogenomics and must be embedded into clinical pathways across specialties to improve care for individual patients.

Cyber security is a crucial area that needs to be considered and addressed. Support will be needed for many smaller organisations, such as community pharmacy and other community services to increase their ability to implement cyber security as it is becoming more and more difficult to counter cyber threat.

What is needed:

- Pharmacists and their teams need to be supported and resourced to enable them to use remote consultation technology effectively
- The skills of pharmacists need to be integrated into the delivery of care as innovation around medicines, such as pharmacogenomics, is developed

4. Governance

RPS view:

Clinical and Care Leadership. Please see our views under Leadership on page 2. It is critical that there is an Executive Pharmacist that sits at the Integrated Care Board of an ICS. This is not currently a requirement of the proposed Health and Care Bill but getting the most value out of medicines is an essential function of an ICS. Medicines are an integral part of ICSs, whether is is prescribing, deprescribing, supporting clinical care, reducing admissions or harm from medicines, shared decision making, persoanlised care etc and pharmacists, as experts in medicines and their use, must be involved in any decisions around medicines within a system.

[7] https://www.rcplondon.ac.uk/projects/outputs/personalised-prescribing-using-pharmacogenomics-improve-patient-outcomes

We are also aware that it will be the governance arrangements that underpin the ICBs that will enable meaningful engagement at place and neighbourhood levels and it is essential that pharmacists are involved in decision making groups or sub groups, which has not happened in the past.

Collaborative commissioning and development of services: New ways of working and delivering care across systems need to be developed to ensure the right professional is providing the right element of the patient pathway. There needs to be more collaborative commissioning opportunities with innovative approaches, engaging with the workforce and delivering population health. Services commissioned by ICS need to be designed and organised to reflect the expertise of those who provide the care, including pharmacists and the wider primary care teams. PCNs and ICSs need to engage with primary care providers to understand how they can support local population health approaches and new innovative services. As credentialling for the pharmacy profession develops there is a need to ensure that commissioning of services is explicitly linked to credentialed level of practice.

The services that are commissioned must not increase disparities in provision and health inequalities should be at the forefront when decisions about services are made. Consideration needs to be given as to how best to use the pharmacy workforce to deliver population health and support people with long term conditions. This may involve the need to consider potential patient registration with a community pharmacy for devolved LTC management alongside shared care records and future IP practice. In Japan they provide a service in which patients select a single pharmacy to receive medication services. The findings indicate that highly tailored, in-person services provided by “My Pharmacists” are associated with not only the degree of patients’ overall satisfaction, but also their evaluation of “the quality of pharmacist services.” [8]

Once a patient has been diagnosed with a long-term condition and stabilised, ongoing support should be provided by an appropriate multidisciplinary team, including community pharmacists, which provides patient-centred, integrated care.

With continued pressures on teams, it is more important than ever to support collaboration across primary care to deliver the best outcomes for patients. A significant percentage of GP time is spent treating common ailments that could be self-managed or managed in pharmacy. The Community Pharmacist Consultation Service (CPCS) is just one example of how we can use the skills of teams across community pharmacy, general practice and the wider NHS to help patients see the right clinician at the right time. We would also like to see the development of a national Pharmacy First scheme across England.

There is a need to consider primary care more holistically, managing workforce, workload and funding, so that the system improves as a whole. PCNs are somewhat limited by contracting and administration requirements and could have been better enabled to allow more innovative approaches to commissioning support from community pharmacy.

ICS leads will need to support the implementation of nationally commissioned services across contractor professions such as pharmacy, as well as determine what additional services may be required locally within primary care. System leaders will need to ensure the delivery of the key aims of, coordinating pharmacy teams and resources across the system, driving the delivery of national strategic priorities and the NHS Long-Term Plan objectives relevant to the pharmacy professions at system and local levels, and providing assurance of good system governance. This is why there will need to be pharmacist leaders appointed at different levels of the system. As responsibility for the delivery of the national contract for community pharmacy is devolved to ICSs they will need to have a pharmacist on their board who can help navigate this contractual framework and help to demonstrate where it fits within the wider system.

Experience of local NHS bodies has shown that community pharmacy and other primary care providers have at times been marginalised in decision-making. If we are to develop innovative approaches to patient care within an Integrated Care System, working across primary and secondary care settings, pharmacy must be included alongside other partners. The primary care hierarchy needs to be addressed and disrupted. The value of primary care as a whole needs to be understood which

[8] https://www.sciencedirect.com/science/article/abs/pii/S1551741119300221

includes an understanding of all the primary care roles in supporting patients and members of the public in their health and care journeys.

What is needed:

- A commissioning landscape that includes all primary care providers and commissioners across patient pathways, led by the ICS
- Enhanced and advanced services and incentives in primary care need to promote collaboration rather than competition
- The governance around how pharmacy will be included in ICB and ICS plans needs to be made clear.

Medicines Optimisation: Medicines spend is the largest spend in the NHS after staff wages. The use of medicines is the most common intervention made in patient care. The total expenditure on medicines in England by the NHS in 20/21 was estimated to be £16.7 billion[9].

National guidance encourages the appointment of a lead pharmacist at ICS level to lead on the development of an Integrated Pharmacy and Medicines Optimisation (IPMO) plan. Having an executive level lead pharmacist to develop and implement this plan will ensure access to medicines, maximising patient outcomes, medicines sustainability and efficiency, all while ensuring safe prescribing and best use of medicines. The lead pharmacist will establish an ICS Medicines Optimisation Committee (or equivalent) acting as single point of contact for medicines at ICS level and co-ordinating medicines optimisation across all care settings. The MO Committee would establish sub-committees as required, such committees will need to be diverse and inclusive of the system, strive for equity across the system, devolve resource and decision-making and support research and spread innovation.

Medicines are a significant part of most patient pathways, so must become integrated into them to support population health and better patient outcomes. Pharmacists have touchpoints with the whole of the medicines pathway, from procurement right up to when patients are supplied their medicines, and pharmacists also have a significant role in supporting people in taking their medicines as part of shared decision-making conversations, thereby preventing significant medicines waste.

Pharmacists will be central to supporting the NHS recovery, including through increasing use of Pharmacist Independent Prescribers and commissioning innovative services to enhance patient care. This should include using pharmacists' expertise to improve prescribing and reduce medicines waste, as well as expanding the role of community pharmacists in medication reviews.

Within primary care, clinical pharmacists work as part of a multi-disciplinary team in a patient-facing role to clinically assess and treat patients, using their expert knowledge of medicines. They will undertake structured medication reviews to proactively manage people with complex polypharmacy, especially the elderly, people in care homes, those with multiple co-morbidities, frailty and people with learning disabilities or autism. Clinical pharmacists play a key role in helping to deliver the new network service specifications, particularly the delivery of the structured medication reviews, enhanced health in care homes, delivering personalised care and supporting the work on cardiovascular diagnosis and prevention. They also have a significant role in supporting further integration of PCNs and general practice with wider healthcare teams, particularly with their clinical colleagues in community, mental health and hospital pharmacy

Implementation of the National Overprescribing Review[10] is key to exploring how medicines are viewed differently and ICSs will need to explore how pharmacists, and other clinicians, can be best supported to put those recommendations into practice. Any changes to medicines should not be

[9] https://www.nhsbsa.nhs.uk/statistical-collections/prescribing-costs-hospitals-and-community-england/prescribing-costs-hospitals-and-community-england-202021

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1019475/good-for-you-good-for-us-good-for-everybody.pdf

completed in isolation, but consideration should be given to the entire supply chain from procurement through to patient impact. As the number of individuals with multiple morbidities become more prevalent, the challenges associated with prescribing the right medicines and supporting patients to use them effectively should not be underestimated. This increase in complexity means that besides developing and maintaining prescribing competency for individual conditions, prescribers have the challenge of keeping up to date with new medicines, manage the risk of adverse events and the potential for interaction between medicines prescribed for different conditions. Managing polypharmacy is where the expertise of the pharmacist is essential as part of multidisciplinary approaches to care. The in-depth pharmacology, therapeutics and medicines expertise of the pharmacist is essential when considering the optimal medicines regimen for a person with multiple morbidities.

The abolition of the CCGs and how medicines are commissioned will require pharmacy leaders to engage with PCNs and provider collaboratives to implement strategic plans and services that would normally be undertaken by CCGs..

Medicines also play a big role in the sustainability / Net Zero agenda and the adoption of a net-zero approach to the procurement and use of medicines. Pharmacists and their teams can undertake a number of actions to support this ambition in terms of the medicines' agenda[11], including:

- Taking a person-centred approach to medicines use. Patients must be well-informed and actively involved in decisions about their care
- Providing medication reviews to identify potential medicines waste, improve compliance, deprescribe medicines not required, and change from high to low carbon products and low environmental impact alternatives where appropriate
- Educating the public about not stockpiling medicines, only ordering the repeat medications they need, and disposing of unwanted medicines appropriately

EXAMPLE: See case studies 3 and 4 in RPS Recommendations and Case Studies for Integrated Care Systems.

What is needed:

- ICSs must appoint a chief pharmacist on their ICS board to support the whole of the pharmacy workforce and to ensure medicines optimisation across the system.
- Taking into account the spend on medicines, medicines optimisation and the utilisation of the skills and expertise of pharmacists, needs to be a key priority for systems
- Medicines must be seen by the system as an investment and not a cost. Focus has to be on using this investment wisely, and recognition that good prescribing reduces health inequalities, improves outcomes and is effective at reducing overall healthcare resource utilisation

Investment: There needs to be adequate investment in primary care as this is where the majority of an individual's health and care needs are met.

Funding must be adequate to support the delivery of high-quality services at both place and system levels. Ideally there would need to be real organisational restructures so that the funding follows the patient flow through the whole of the system. This will mean that the funding is linked to function rather than form and would ensure that patients receive the most appropriate services for their needs at any one time in their patient journey.

[11] https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/sustainability-policy/policies

Currently, different parts of the system have different methods of grading staff. In the future, it would be beneficial to explore how a payment structure could be managed across all of the system as this would aid portfolio working and also enhance career development across the wider system.

Leadership: There needs to be a strong voice for primary care at system leadership and place-based levels. This must take place through critical leadership roles including pharmacy, clinical directors, teams across Primary Care Networks (PCNs) who build partnerships in neighbourhoods spanning pharmacy, general practice, community and mental health care, social care, dentistry, optometry and the voluntary sector. Please also see the section on leadership under workforce.

5. Data, population health management, demand / capacity, risk stratification and health inequalities

RPS View:

Please also see our response under Non-Physical Access.

As we have mentioned previously, having access to the information about the person you are caring for is critical to making good clinical or care decisions. All health and care professionals who interact with patients will need to have read and write access to the relevant information so as to provide the best possible care. This also means individuals themselves having access to their records and being able to input data such as blood pressure readings etc.

EXAMPLE: See Case Study 6 in RPS Recommendations and Case Studies for Integrated Care Systems

Standardisation of data: Data should be collected and shared in standardised formats so that it is easily transferred across systems. Consideration needs to be given to developing national guidelines to prevent duplication, particularly in applying digital standards and Information Governance processes. The interoperability of data is also key to information sharing and the current clinical standards that the Professional Records Standard Body produce need to be supported and implemented across systems. Having this standardisation will also enable optimal referral pathways that facilitate the referral of patients to and from different parts of the system and across different health and care providers.

What is needed

- Clinical standards need to be developed at a national level and become embedded into all IT systems

Data driven care: We have referred to the need to use data consistently to support the development of services that are needed for the population they are aiming to serve, including addressing health inequalities. We have also mentioned that community pharmacies may hold relevant data on the local population that is currently not shared with the wider system. Both primary care and the wider ICS, need to engage with pharmacies to support the interpretation of the data they hold so they can better deliver population health and base the care provided on the data available.

There is a real need to use population health data to determine the needs of a population and we believe that the place-based level is probably the best level for this. Places need to gather intelligence across their population using existing networks and then use this population health data to find out which communities are being underserved, and where the gaps are. And this gathering of data needs to include all of those involved in the provision of health and care for the local population.

In terms of pharmacy and medicines we believe that pharmacists need to work alongside their ICS digital transformation teams to ensure alignment with medication supply and to support primary care access demands such as enabling digital prescription request access.

Systems need to create single access dashboards to support pharmacy baselines and quality information data gathering to encompass all sectors of pharmacy, which will support the triangulation of services and better patient care.

What is needed:

- Dedicated data analytics resource within PCNs and ICSs
- Engagement with all elements of the system that collect and hold relevant data on the local population
- Visible website per ICS that is public friendly and updates on what is happening and how to get involved

6. Communities and Engagement

RPS view:

Personalised care: It is essential that all those providing care to patients and the public have a good understanding of personalised care and what this means in terms of the care they are providing. In terms of pharmacists and their teams, much of their interactions with patient and the public is around the medicines they are taking or in providing health and lifestyle advice. Being able to have shared decision-making conversations with patient and the public will lead to people having a better understanding about their medicines and enable individuals to make informed decisions about their care. In the longer term this will lead to better patient outcomes.

However, not every interaction needs to involve a medicine and there is more that pharmacists and their teams can do in terms of non-medical interventions. To date, pharmacists working in primary care have not been fully integrated into social prescribing. Pharmacists, particularly those working in the community, often see people who would benefit from social prescribing before the individual feels the needs to access other parts of the health service. This provides an opportunity to identify people earlier on and refer them to a link worker for the support they need.

Health care needs to be holistic. It is not about just responding to ill health and treating symptoms but addressing and preventing drivers like social injustice and health inequalities. The personalised care approach empowers and enables people to take control of their health and wellbeing, which improves health outcomes. Health care professionals across the system need to support people to be empowered.

What is needed:

- Pharmacists need to be supported, in terms of education and training, to enable them to have shared decision-making conversation with patients and the public
- Fully explore the role of pharmacists in social prescribing

Co-production: In order for ICSs to deliver the best services for their population they need to engage patients and the public in the development of the service, right from the initial development. Health and care professionals need to work with their patients and members of the public to understand what

they need to improve their health and care. This obviously links to being able to collect the right data across a system and interpret it to demonstrate what is happening currently in a locality.

General practices have patient participation groups (PPGs) which help to inform the direction of travel for that practice. PPGs could be used across PCNs to help inform the development and delivery of all of primary care within an area.

What is needed:

- Explore the use of patient participation groups across a PCN

Know your population: It is important that PCNs understand who their population are, the diversities within their populations, and therefore their diverse needs in terms of health and care support. PCNs, and also ICSs, need to have flexibility to deliver the care that is needed to meet the needs of their populations.

Local pharmacy teams can act as champions and play an active role in breaking down the invisible barriers of tradition, religion and culture, and engaging with their communities. Community pharmacy staff often live within the same area where the pharmacy is located and have an understanding of the cultural differences within the local communities enabling them to adapt the way they communicate with patient and the public. For example, they may speak one of the local dialects or languages and so be able to communicate with patients or the public in their language of choice.

Pharmacists can have a key role to play in dispelling myths and creating trust within localities. By understanding the local cultures they are able to explain the benefits of a service or why someone should consider doing something and this will impact on how an individual takes responsibility for their own care.

What is needed

- Real engagement with local communities to understand their diversity and their needs

Social Care. ICS have responsibility across health and social care and the Integrated Care Partnerships will be critical in ensuring that these two elements of care come together to benefit patients and the wider population. Pharmacists working in primary care have a significant role to play in supporting the social care agenda. This is particularly apparent in care homes and we welcomed the national investment from NHSE/I in recent years to support the role of primary care pharmacists working in care homes to support residents and staff around medicines.

Pharmacists are also working in local communities and have a significant role in supporting people to be able to access their care closer to home. Many frail and elderly people, people with complex care or those with multiple LTCS are often taking several medicines and may be struggling to manage them all. Enabling pharmacists to support patients in their own homes in terms of medicines optimisation will help to provide better outcomes for these patients and potentially prevent them needing more advanced care.

Mental Health: Many people with mental health problems experience poorer care than they should, and much of this relates to getting the right treatment. Pharmacists can play a vital role in providing accessible services to support people's mental health, not only to help people get the most from their medicines, but also around looking after their general health and wellbeing. Whether it is spotting early signs of mental health problems, managing long-term conditions, providing expert medicines advice to colleagues or signposting to other forms of support, pharmacists working across the system are ideally placed to ensure people get the help they need.

Specialist pharmacists working in mental health services already contribute to the provision of expert mental health care and provide valued expertise and training in the use of medicines to professional colleagues. This specialist expertise needs to be made much more widely available to enable services to be developed across other settings

There are opportunities to further help people with serious mental illness improve their physical health, through the provision of physical health checks and an environment focussed on wellbeing. Community pharmacists and their teams could play an increasing role by ensuring they are trained as mental health champions and in mental health first aid.