PM Healthcare
PROGRESS THROUGH PARTNERSHIP

JOURNAL

Incorporating *The Journal of Pharmacy Management* and *The Journal of Medicines Optimisation*

Winter 2025 | Issue 11

Highlights:

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PM Healthcare
PROGRESS THROUGH PARTNERSHIP

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Do you have an idea for an article or an area that you think we ought to be covering in the Journal?

If you have an idea for an article that you would like to discuss then please get in touch to see if we can include it in the Journal.

We are very keen to support healthcare professional who want to write about:

- Their experiences working in pharmacy and the related professions
- Examples of best practice
- Ideas and innovations that have improved patient care
- Clinical studies and papers that are of interest to a HCP audience, with a focus on pharmacy
- ICS/ICB-led initiatives in pharmacy, medicines optimisation and management
- System changes and reforms that have improved patient care locally and are capable of being scaled up
- Career development stories that will inspire the next generation of pharmacy graduates
- Opinions and commentary from those delivering services

These are just a few of the areas that are of interest to our readers and that contribute to our objective of bringing you insightful and relevant content that translates into best practice and practical application.

Please contact me with ideas at:

John Chater, Editor – PM Healthcare Journal E: editor@pmpublications.co.uk

Editorial

In the juvenescence of another year, we look ahead and wonder what awaits pharmacy services.

Six months into the life of the new government, and we have seen a succession of announcements relating to the future of the wider NHS, focusing on staffing, funding, efficiency, tackling inequalities and other entrenched issues, all of which resonate with pharmacy.

Health Secretary Wes Streeting has taken honesty to new levels, decrying the state of the service, which he has repeatedly described as broken. Proposed solutions so far include a(nother) review by Lord Darzi, setting out the bones of a(nother) ten year vision.

Integration is still the order of the day, with a continuing emphasis on the role of primary care to reduce hospital pressures and localise services. Improved technology, including the spectre of AI, is also seen as essential to the NHS's future recovery.

Which, to some of us, might sound a little like 'jam to-morrow and jam yesterday – but never jam to-day', as these 'wicked problems' re-present themselves annually. Post-Covid, post-Brexit, post-election – we are still waiting for the green shoots of recovery to really appear, let alone the brave new world of opportunity that they promise.

In this, our first PM Healthcare Journal of 2025, we have an in-depth and UK-wide analyses of the community pharmacy sector, conducted by David Tamby Rajah, asking what lessons England might learn from the integration of services in the Celtic Nations to move from a Pharmacy First position to 'Pharmacy Forward'.

In our clinical section, Michael Wilcock, Liam Bastian and Alison Hill describe the views of pharmacy professionals in general practice on improving discharge medication information, and Kavan Nagi, Ann Parker, Hannah Oatley and Claire Norfolk provide reflections from a secondary prevention project on the role of the clinical pharmacist in lipid optimisation in primary care.

Suhrab Sayfi identifies the potential of secondary care pharmacy in bridging health gaps and tackling health inequalities. And, as an example of innovation in the delivery of homecare, Personal Homecare Pharmacy shares its experience of developing and implementing its own digital solutions.

And we also have an inspiring and personal perspective from student pharmacist Kanupriya Sachdeva, who describes with passion and enthusiasm what a career in pharmacy means to her, and how she sees the profession as a vital part of improving healthcare not just for the UK but also for the world.

Passion and enthusiasm – exactly what we need as we navigate the dark months of winter whilst looking ahead to a brighter new year.

As ever, please contact me with any ideas you have for articles and experiences you would like to share. Also, if there is a subject area that you would like to see covered in the Journal, perhaps in a special edition, do not hesitate to get in touch.

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Achievements of Community Pharmacy Integration in the Celtic Nations – What are the lessons for England to move from Pharmacy First to Pharmacy Forward?

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Introduction

All four UK nations have their own Pharmacy First or Common Ailments Service, of which the Celtic Nations have a more established and larger service per capita than England, as evidenced in this article.

In England, the current Pharmacy First service is a success story, hailed by Lord Darzi as an example of 'Value-added services' for the NHS, provided by community pharmacy. This key service supports general practice as part of the Delivery Plan for Recovering Access to Primary Care Services (below). The fast timescales to launch the England service is a success story, and this achievement needs to be built on.

I have noted that the ongoing contract negotiations and pharmacy funding issues are still taking place. This has added pressure to community pharmacies and needs to be addressed to ensure services such as Pharmacy First can be a success.

The article is written with respect.

Concerns were expressed mid-2024 that community pharmacy contactors would struggle to achieve their minimum activity requirements due to low activity levels. NHS Business Services Authority (NHSBSA) claims data showed in June 2024 that activity was down 2.3% from levels in May 2024. In response, at the Pharmacy Show in October, NHS England announced consultation thresholds were to be reduced to 20 in November and December 2024, the number of consultations then changing as follows:

- **November and December 2024:** 20 clinical pathway consultations.

Delivery Plan for Recovering Access to Primary Care and Pharmacy First

On 9th May 2023, NHSE and DHSC published the Delivery Plan for recovering access to primary care.

The plan includes a commitment to:

- Commission community pharmacies to deliver a Pharmacy First service by enabling the supply of NHS medicines for seven conditions
- Increase provision of the community pharmacy NHS Pharmacy Contraception Service and the Blood Pressure Checks Service.
- Invest to significantly improve the digital infrastructure between general practice and community pharmacy.

- **January and February 2025:** 25 clinical pathway consultations.
- **March 2025:** 30 clinical pathway consultations.

The reasons for low referrals are explored below.

Community pharmacy integration in Scotland, Wales, and Northern Ireland has seen significant achievements that provide valuable lessons. The fundamental question to answer then, is: What can be learned from the Celtic Nations to improve Pharmacy First in England? The intention is to identify areas of service improvement that will be beneficial to the England model, comparing the experiences of the Celtic Nations. In this article, pharmacy leaders across the UK have shared their perspectives.

"The achievement in launching Pharmacy First by NHS England and Community Pharmacy England in a short space of time should be acknowledged at the outset. Now, there is an opportunity to learn from the Celtic Nations to make Pharmacy First more active and support primary care recovery."

We might say at the outset that England has reached the 'base camp' with the launch of Pharmacy First, and there now needs to be further changes and improvements made to progress the service to a 'Pharmacy Forward' position.

England

Pharmacy First

In writing this article, I interviewed integrated care board (ICB) chief pharmacists and local pharmaceutical committees (LPCs). The one key feedback was the success in delivering this service in a very tight timeframe. Comments received made it feel very much as if the foothills of Everest had been reached, the challenge ahead being maintaining and ascending the mountain.

Pharmacy First was launched on 31 January 2024, with the aim of giving patients quick and accessible care for seven common conditions listed below:

1. Impetigo (aged 1 year and over).
2. Infected insect bites (aged 1 year and over).
3. Earache (aged 1 to 17 years).
4. Sore throat (aged 5 years and over).
5. Sinusitis (aged 12 years and over).
6. Urinary tract infections (UTIs) (women aged 16 to 64 years).
7. Shingles (aged 18 years and over).

The service is designed to relieve pressure on GPs as part of the Delivery Plan to for recovering access to Primary Care.

Key facts and data

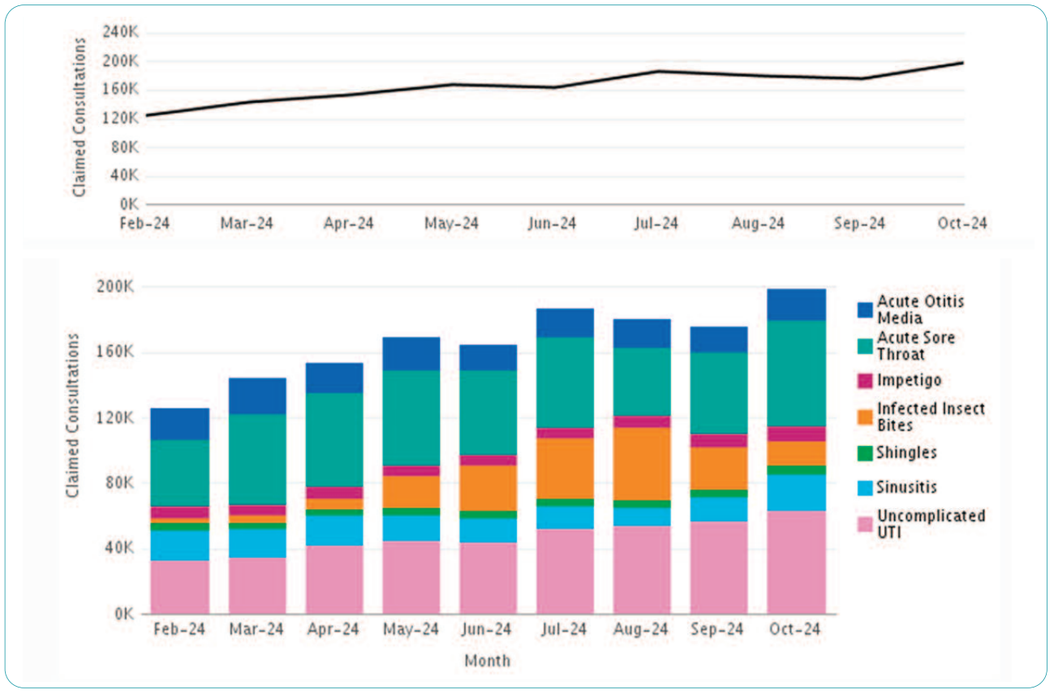
- Pharmacy First sign-up was over 95% of all community pharmacies.
- NHSBSA data revealed that pharmacies in England delivered an average of 16.8 NHS Pharmacy First service consultations for the seven clinical pathways in April 2024.
- In April 2024, 1,598 pharmacies recorded no consultations under the clinical pathways, and 785 secured between one and five consultations, lower than the threshold for the month.
- At the current rate of activity there could be an underspend of the £645m the government has allocated (by the end of March 2025).
- £2,000 in upfront Pharmacy First funding is set to be recovered from a total of 555 contractors. The NHSBSA indicated the initial £2,000 would be 'recovered' from contractors if they 'had not delivered five clinical pathways consultations' by March 31, 2024.

Lord Darzi review of NHS England

The Darzi review of the NHS in England has several implications for community pharmacies, highlighted below:

Potential for growth

The review highlighted the value of community pharmacies, including their ability to reach people in deprived areas and provide services like



Pharmacy First. It also notes the potential for pharmacists to become independent prescribers and provide more clinical services.

Funding and resources

The review warns that community pharmacies lack funding and resources, and that they are at risk of facing similar access problems to general practice. It noted that spending on the community pharmacy contract has fallen by 8%, while pharmacies have expanded their clinical services.

Need for action

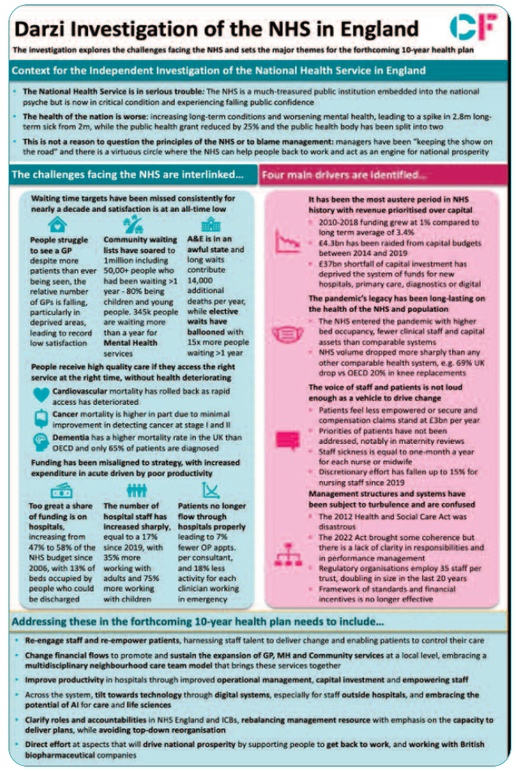
Community pharmacy leaders have called for urgent action to invest in the sector and stop the closure of pharmacies. The review's recommendations support a shift of care from hospitals to communities, and a need to spend more on preventative care.

Long-term reform

The review's remedies and fixes are not quick, and the NHS is unlikely to see notable improvements in the short or medium term. However, it is crucial to take steps now to revive the NHS.

Consultations

In January 2024 there were 125,275 consultations and in July 2024 there were 186,190 consultations, this demonstrated that consultations are steadily rising as evidenced by NHS BSA Data.



Issues with Pharmacy First

The seven clinical pathways

- Pharmacists in England are experiencing increasing pressure to meet the minimum activity thresholds for the Pharmacy First clinical pathway consultations.
- Pharmacists also report challenges with inappropriate referrals and patients who do not meet the eligibility criteria, adding to their workload.
- A review of the clinical pathways is needed to look at clinical exclusion criteria.

General practice challenges

- General practice hesitancy to refer patients to community pharmacies could stem from factors such as no Pharmacy First end-point integration within total triage tools, the rise of online consultations, or a lack of confidence in front-line teams. A deeper investigation into these issues is essential.
- Some GP practices are signposting rather than referring into Pharmacy First services.
- Integration of community pharmacy and GP practices is variable across England. An improved understanding of The Community Pharmacy Contractual Framework (CPCF) and the GP General Medical Service (GMS) and Personal Medical Service (PMS) contracts would improve mutual understanding of both professions' priorities.
- GPs complete total triage most of the time not receptionists. Receptionists fill out the forms in this route and all are assessed by a GP or advanced clinician. There is an opportunity to provide dedicated training for GP receptionists to support GPs in Pharmacy First referrals.

Public marketing and workload Implications

The second phase of the advertising campaign promoting Pharmacy First, highlighting how community pharmacists can now provide treatment and some prescription medicines for the seven conditions without the need for a GP appointment or prescription, has been launched.

This campaign could be developed further with ICBs working with placed-based stakeholders to have focussed promotional campaigns linked to local population needs. A good example is targeting communities where English is not a first language, encouraging communities to make better use of community pharmacies.

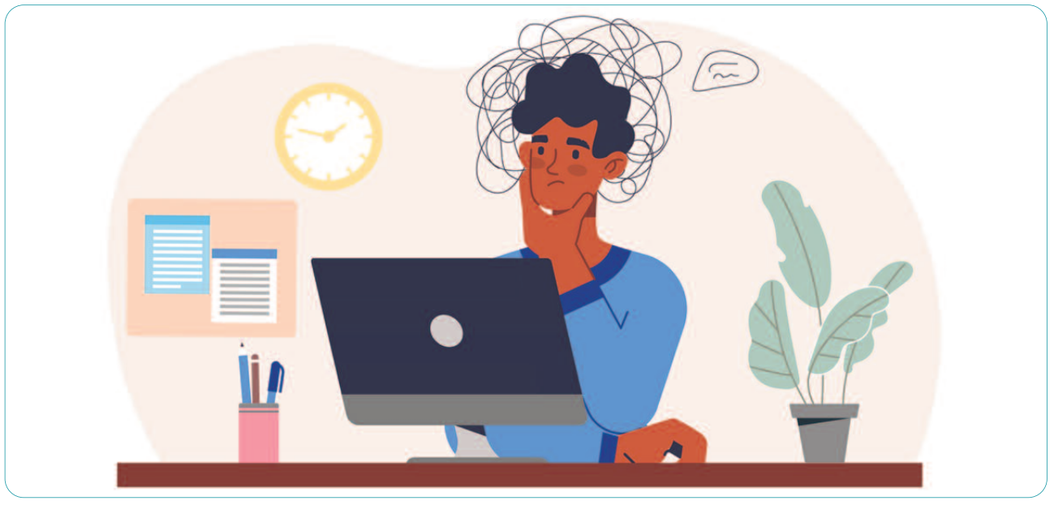
Public awareness and expectation in future campaigns should not inadvertently increase the workload of pharmacy teams beyond expectation. Striking the right balance will be key to the programme's success. More work is required to educate patient groups who would not normally access community pharmacy services, and resources must be embedded to tackle health inequalities. There are opportunities to promote NHS community pharmacy services and raise awareness with local communities working with ICB placed based teams and local authorities.

Workforce training hubs: Scope and scrutiny expansion beyond general practice

It is imperative to review how training hubs operate, particularly their focus on general practice to the exclusion of other primary care sectors like community pharmacy, dentistry, and optometry.

> **"Training hubs should undergo more rigorous scrutiny by the NHS Workforce Training and Education (WTE) team to ensure that all healthcare professionals have equitable access to training resources. If this is not feasible, reallocating budgets to specific providers may need to be considered."**

Integration of the Centre for Pharmacy Postgraduate Education (CPPE) could be enhanced, with training hubs and training programmes applied uniformly across the sectors and services such as Pharmacy First.



IT connectivity barriers of service in GP

The truncated launch time for Pharmacy First has meant IT platforms had less time to be implemented effectively resulting in service issues.

As in community pharmacy, all GP practices work and are configured differently – therefore a 'one size fits all' IT solution may not fit at all. A lack of technological integration will require specific adaptation to achieve Pharmacy First referrals.

Pharmacies have experienced several IT issues with the Pharmacy First service. For example, discrepancies in the NHS Manage Your Services portal (MYS), which was recording fewer consultations than pharmacies were entering.

Community Pharmacy England has made the following recommendations to pharmacy staff to address IT issues:

- Register for spine alerts.
- Staff can receive text or email alerts if the national NHS Digital systems are experiencing issues.

A root and branch review is required to see how primary care provider IT systems are managed and connected. This applies to not only general practice and community pharmacy, but also dentistry and optometry. Any review would need to consider workflow and how referrals can be more easily made between providers.

ICB delegation

Across England, there are huge variations in uptake of Pharmacy First across ICBs.

In July 2024:

- Over 10,000 consultations took place in two ICB areas.
- In four ICBs, less than 2,000 Pharmacy First Consultations occurred.

There is an opportunity to programme manage Pharmacy First delivery through the NHS England regional teams with their constituent ICBs. Best practice, resources and service issues could be shared to achieve a standardised approach.

There is variability in how effectively ICBs have embedded the Community Pharmacy Contractual Framework. All ICBs have had to recruit clinical community pharmacy leads, supported by 18 months of funding. However, it is not clear if any of these positions have been made substantive.

Workflow

Pharmacy First is a referral service and is a fundamental change to the way traditional dispensing community pharmacies work. There are challenges balancing the number of services – dispensing and operational management analysis is required.

Despite these challenges, community pharmacies have delivered 125,000 consultations in the first

month of the Pharmacy First programme, which shows the dedication and willingness to make this service work.

I met many community pharmacists at the 2024 Pharmacy Show in October 2024 and it was made clear to me how important the service is and how improvements would improve performance.

Supporting Pharmacy First Success

There are many examples of Pharmacy First best practice in England. The case study below highlights how innovative thinking can help progress Pharmacy First to 'Pharmacy Forward'.

Leadership and place-based investment: A case study

The work led by Vanessa Burgess, Chief Pharmacist in South East London (SEL), on local place-based leadership is a model that highlights the collaboration between SEL ICB and the LPC, under the leadership of the ICB Chief Pharmacist and SEL LPC CEO Raj Matharu. It has successfully addressed the gap in community pharmacy leadership.

The tripartite system developed – comprising LPC oversight of primary care community pharmacy services, the operational support provided by SEL Pharmacy Alliance, and the development of Community Pharmacy Neighbourhood Leads (CPNL) – represents a forward-thinking approach that could serve as a blueprint for other regions.

The ambition is for the CPNLs to develop a cross-sector pharmacy clinical network, to improve patient outcomes and provide the NHS value proposition for patient services including Pharmacy First, Pharmacy Contraception service and Hypertension Case Finding Service.

Scotland

NHS Pharmacy First Scotland

In July 2020, The Scottish Government launched the NHS **Pharmacy First Plus**, replacing the previous Minor Ailment Service that had been in place since 2006. The new service, successfully launched during the Covid 19 pandemic, marked a significant step forward in the care of common clinical conditions by community pharmacy. It is available to patients registered with a GP in Scotland.

Pharmacists working within the NHS Pharmacy First service provide NHS care for various acute, common clinical conditions (see below) through consultation, advice, treatment and appropriate referral to other healthcare professionals.

The service supports care in the most appropriate community pharmacy location, freeing time and resources for more complex care in GP practices and emergency departments. Pharmacists are funded through a base payment and additional activity model, and since inception, more than five million consultations have taken place.

The NHS PFS model aims to enhance the efficiency and accessibility of healthcare services, but its success depends on effective implementation, continuous evaluation, and addressing the potential challenges associated with it. Ongoing review involves assessing the current service, reviewing patient needs and, subject to funding, developing the service further.

In 2020, a community pharmacist independent prescribing service for common clinical conditions, NHS Pharmacy First Plus, was introduced, the intention being to have an independent prescribing service in every community pharmacy in Scotland. Continued investment into the training of community pharmacists to become independent prescribers will support the delivery of the strategic aim to offer the service from all community pharmacies in Scotland.

Case study performance of the NHS Pharmacy First Model in Scotland

The NHS PFS Service data from April 2021 to March 2024 shows the following:

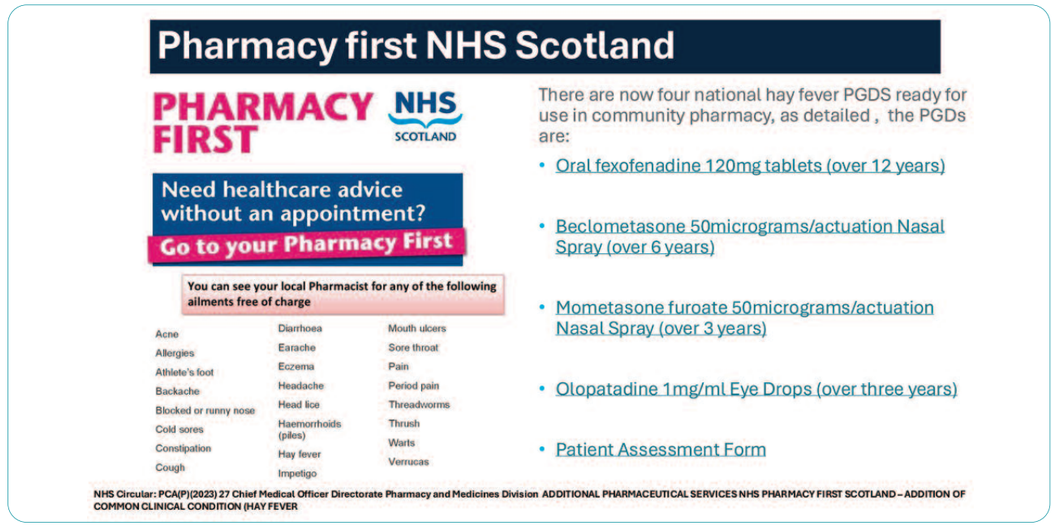
- 32% of the Scottish population (1,747,654 people) used Pharmacy First.
- The number of people using Pharmacy First at least once in a 12-month period since reporting began increased by 41%, from 1,242,842 in 2021/22 to 1,747,654 in 2023/24. This increase can be seen in both males and females, and across all age groups and deprivation quintiles.
- Over 84% of people who used the service received an item at least once. Alternative outcomes to contacts are advice only (for example guidance on self-care) and onward referral to another health professional.
- Of the people accessing the service, 60% were female.
- The highest rate of Pharmacy First use was in the 0-9 years age group (252 per 1,000 population in the most recent quarter). This has been the case in each quarter since reporting began. The most recent quarter reported, January to March 2024, also saw the highest use of the service in every age group except the 90+ group.
- Use of Pharmacy First Scotland can be seen across all levels of deprivation in the population. (In 2023/24, 43% of patients lived in the two most deprived quintiles.)

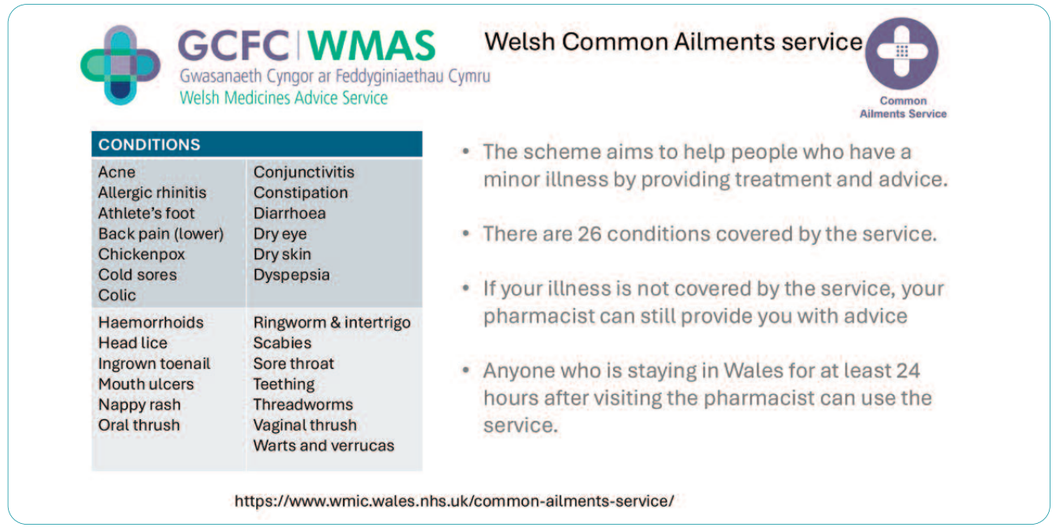
Wales

The Common Ailments Service

In Wales, the Common Ailment Service (CAS), launched in 2013, is a Patient Group Direction (PGD) service offered by local pharmacies that provides patients with free NHS advice and necessary treatment for the 26 minor conditions shown below.

Wide-ranging reforms to contractual arrangements in April 2022 – described in *Presgripsiwn Newydd – A New Prescription* – placed much greater emphasis on the provision of clinical services from pharmacies. These reforms, agreed by the Welsh Government, Community Pharmacy Wales, and





Local Health Boards, brought four core NHS services into national commissioning:

1. The Common Ailments Service (CAS).
2. Emergency Contraception.
3. Influenza Vaccination.
4. The Emergency Supply Service.

Presgripsiwn Newydd also announced a national Independent Prescribing Service for a range of extended minor illnesses not covered by the CAS, and contraception. These services allow patient self-referral or informal signposting from any other setting. In the year following launch, more than half a million consultations took place across the four core services (the increase in service activity can been in the table below).

"Community Pharmacy Wales data shows that the Welsh community pharmacy network now delivers over 65,000 clinical services consultations every month. Recent expansions to the CAS include optional sore throat test and treat, and UTI services, providing further opportunities for patients to access acute care closer to home."

The year-on-year increase in consultations suggests that the patient population has faith in the sector, which in turn releases more time for GP and out-of-hours partners to deal with more complex and chronic illnesses.

Alongside the Pharmacy Independent Prescribing Service (below), emergency medicines supply, flu vaccinations and contraception, community pharmacy in Wales has achieved all of the objectives set in *Presgripsiwn Newydd – A New Prescription.*

The CAS has been well received by community pharmacy contractors, patients and the Welsh Government. It is not an overestimation to say that the growth of the CAS has exceeded expectations and has provided a positive case study on how community pharmacy can support the NHS whilst releasing pressures elsewhere in the system.

The Pharmacy Independent Prescribing Service

In Wales, the Pharmacy Independent Prescribing Service (PIPS) has expanded from 34 sites in 2022, to 200 sites in September 2024 (almost 30% of all pharmacies). There are currently 12,000 consultations a month in these sites with (in real terms) 93% of patients reporting they would otherwise have seen a GP if the service were not available.

The intention is that PIP services will become available in every community pharmacy, at which point the range of conditions included in the CAS will need to be revisited, along with new funding structures to determine whether it will remain exclusively pharmacist led.

Service included in CCPS	Percentage of pharmacies providing immediately before reforms	Percentage of pharmacies providing one year after reforms	Increase
Common ailment service	99.3%	99.4%	0.1%
Emergency contraception	90.4%	99.4%	9.0%
Emergency medicine supply	93.0%	99.4%	6.4%
Seasonal influenza vaccination	90.4%	99.4%	9.0%

A healthier Wales

In 2018, the Welsh Government published its long-term vision for health and social care A Healthier Wales. The response of the pharmacy profession, Pharmacy: Delivering a Healthier Wales, provided a consensus view on how pharmacy services should be developed by 2030. Presgripsiwn Newydd and the commitment of the profession in Wales to its delivery will significantly benefit other NHS service providers in Wales and aligns with Welsh Prudent Healthcare principles.

Utilising the workforce and collaboration

Both Presgripsiwn Newydd and Pharmacy: Delivering a Healthier Wales, emphasise an ambition and commitment to progress and utilise the skills, expertise, and accessibility of pharmacists and the wider teams more effectively within communities.

Greater access to NHS care from professionals in a location and at a time most convenient to patients is enabled by a stronger focus on:

- Clinical service provision.
- Workforce development.
- Promoting integration of pharmacies within primary care.
- Continued investment in the sector.

Beside the development of pharmacist-led services, there have been significant moves to utilise pharmacy technicians. Focus has been given to the training and retention of pharmacy technicians, who now deliver almost one fifth of NHS pharmacy services, such as discharge medicine reviews, inhaler reviews and care home review services.

From February 2025, pharmacy technicians in Wales will also be enabled to provide the national contraception service, improving access to emergency and quickstart contraception for patients across Wales.

The NHS Wales's Primary Care Cluster Model has also been reformed. The model aims to encourage collaboration between pharmacies, GPs, and other primary care health professionals, fostering integrated care and improving patient outcomes across Wales.

Common Ailments Service case study

The CAS now delivers over 40,000 consultations a month but is particularly important in managing winter pressures.

In December 2022, during the national Strep A outbreak, community pharmacies delivered 9,508 sore throat consultations to test for Strep A (over double the normal number) without any increase in referral rates or unnecessary antibiotic use. This can also be seen at a local level in Wales. A recent study of Welsh sore throat services showed that 24% of pharmacy consultations ended with an antibiotic prescription, compared with 39% of GP consultations.

Community pharmacy will need to continue to be innovative and learn from experiences in other countries to ensure that the network is best placed to always deliver the needs of the NHS in Wales provided that adequate NHS funding is made available.

Dr Berwyn Owen

Berwyn is a pharmacy proprietor and prescriber in North Wales and formerly a chief pharmacist and a member of the General Pharmaceutical Council. His community pharmacy is located in the village in Penygroes. (It is to his credit that his belief in the value of community pharmacy was so strong he bought a community pharmacy as part of his retirement.)

"The Welsh Common Ailment service has given Berwyn more scope to provide a comprehensive care package to his community."

Northern Ireland

Northern Ireland Pharmacy First

The Northern Ireland Pharmacy First service, launched in 2019, provides easier access to healthcare through community pharmacies for minor ailments and conditions. The service is similar to the service provided in Scotland.

There are three services within Pharmacy First (health and social care in Northern Ireland are integrated):

- Pharmacy First for Every Day Health Conditions covering 13 conditions.
- Pharmacy First for Emergency Hormonal Contraception.
- Pharmacy First for Urinary Tract Infection (UTI).

In addition, the following services have been added on a time limited basis:

- Pharmacy First Sore Throat Service Winter 24/25. Available during December 2024 – March 2025. (extended by the Minister last week at an emergency Health Committee meeting)
- Pharmacy First pilot Shingles 24/25 (limited number of pharmacies). This expected to run from January – March 2025).

Pharmacy First in Northern Ireland is underpinned by:

1. **Additional services:** Community pharmacies in Northern Ireland provide a range of additional services commissioned in line with strategic priorities and may be provided by all community pharmacies if service specification requirements are met (e.g. smoking cessation).
2. **Integration with primary care:** There has been a focus on integrating pharmacies into primary care teams, improving access to healthcare services, and streamlining patient care.
3. **Public health initiatives:** Community pharmacies have been involved in various public health campaigns and preventive measures, contributing to overall health improvement.

In 2023, over 150,000 people used the Pharmacy First Service for one of 13 conditions. In May 2024, the Department of Health unveiled plans for pharmacies to treat six new conditions, offer two new services and run various pilots in its community pharmacy strategic plan. The new services are set to be introduced in the period up to 2030 – 'subject to securing the necessary funding'.

Northern Ireland case study

The evaluation carried out of the pilot sore throat service showed that a total of 6,768 consultations were undertaken in the 43 community pharmacy pilot locations. The feedback from stakeholders was very encouraging, with patients reporting 96% satisfaction levels showing confidence about using the service and advice received from the pharmacist. In addition, GPs who provided feedback said that the service was beneficial to patients.

Patient feedback was positive:

- 93% indicated they received advice on how to manage symptoms from the pharmacist and that this advice was helpful.
- 81% reported feeling confident to manage symptoms themselves in the future.
- 6% indicating that they would be likely or very likely to use the service again and to recommend it to family and friends.

When asked why GPs felt that the service was beneficial to patients, responses included:

- Patients had quicker access to advice/treatment.
- There was an option to do a throat swab to guide treatment.
- Reduced inappropriate prescribing of antibiotics.
- An opportunity to provide patient education about self-care.

The outcome of this successful pilot saw the roll out of a 'Pharmacy First for Sore Throat' Service from community pharmacies across Northern Ireland for this winter.

Terry Mcguire, a prominent community Pharmacy Leader in Northern Ireland said of the Northern Irish Service *'The Pharmacy First Common Conditions service has been available in N. Ireland for over 15 years. The recent growth of the service to include Emergency Hormonal Contraception and bridging contraception (3 months of the pill), UTI and Sore Throat services has greatly expanded the scope and power of the Pharmacy First offering by allowing provision of POMs via PDGs. We can now really make a difference to patient's lives. We introduced the services with enthusiasm and have found a great response from our patients. It significantly enhances the clinical professionalism of pharmacy with the public and our paymasters. Personally, I take great pride in delivering these services and their financial contribution to the business is not insignificant'.*

He would advise better promotion of the service and preferred access to GPs, AEs or OOHs to refer patients who have red flags or just need additional support or assessment.

Health Minister Mike Nesbitt said:

'The Pharmacy First for Sore Throat Service has been proven to offer a high-quality, efficient and effective clinical pathway for people aged five years old and over to receive assessment and necessary treatment for sore throats, helping to free up GP time for management of other complex and urgent cases.

'The Pharmacy First service provides an easily accessible way for people to receive clinical care for common winter illnesses close to their homes or on our high streets without the need for a GP appointment. I have no doubt the extension of the 'Pharmacy First' service to include sore throat will be a welcome addition to the range of clinical care that people can receive in the heart of their own communities from local pharmacy teams. I would encourage the public to avail of these services to help keep well over the winter period.'

Lessons for England

Across the Celtic Nations there is a wealth of experience and local innovation, which would support the NHS in England to increase activity and move to a new mindset of 'Pharmacy Forward'.

The following represent some of the potential opportunities.

Expand the number of conditions in the English Pharmacy First Model

England could benefit from expanding the range of services and expanding the inclusion criteria provided by community pharmacies similar to Scotland's Pharmacy First and Wales's Common Ailment service DES. This could help alleviate pressure on GP services and improve patient access to care and help community pharmacy achieve their threshold levels.

The existing seven clinical pathways in England need to be reviewed to address limitations. This would give community pharmacy a better opportunity to meet contractual thresholds and treat more patients.

Integrated care models

Adopting models that encourage collaboration between pharmacies, GPs and other healthcare professionals, as seen in Wales and Northern Ireland, could enhance patient care and streamline services. This would require more national direction about best models of integration and local commissioning.

Medication management

Strengthening medication review services and support for chronic disease management, as practiced in Scotland and Wales, could improve medication adherence and patient outcomes in England.

Public health role

Increasing the involvement of community pharmacies in public health initiatives could address broader health challenges and promote preventative care. The integration of an emergency contraception service or even a national walk-in smoking cessation service would harmonise the many local authority specifications.

Patient access and convenience

Opening more direct patient referral or referral from other professions would improve patient access to care and reduce the burden on other healthcare services.

Flexible contracting models

Pharmacy First should be integrated into GMS/PMS to be explicitly clear about referrals. The GP prescribing incentive scheme could be further used to set targets.

Embracing flexible and innovative contracting models that allow pharmacies to provide a broader range of services could lead to more effective integration into the healthcare system.

Infrastructure

There needs to be a fundamental re-wiring of information systems to allow GPs to refer into Pharmacy First and connect more efficiently with community pharmacy IT systems.

Workforce

The role of ICB training hubs needs overhauling into a primary care hub that equitably covers general practice, community pharmacy, dentistry and optometry. This would better integrate the four pillars of primary care to focus on primary care recovery. Centre for Pharmacy Postgraduate Education (CPPE) should be locally integrated training hubs.

A pharmacy team plan for pharmacists (IP and non-IP), pharmacy technicians, dispensers, foundation pharmacists and front-line staff, showing how each role could support pharmacy service and the responsible pharmacist lead, would create more effective integration.

Community pharmacy federations could manage training funds for community pharmacies within their region, ensuring that these vital services receive the support they need.

Investment in community pharmacy leadership to improve service uptake and confidence is urgently required. Closer partnership between CPPE and ICB training hubs would improve targeted delivery of workforce needs and create local leadership.

Lessons from elective care recovery

Elective care covers a broad range of planned, non-emergency services, from diagnostic tests and scans to outpatient appointments, surgery and cancer treatment. To date, NHS England reported over 6 million people are currently on a waiting list, waiting for over 7 million episodes of care, like a test or an operation. The Government has announced in January 2025 a new elective care recovery plan proposal to reform elective care and return to the constitutional standard of 92% of patients receiving treatment within 18 weeks. The aim is to build a sustainable NHS that is fit for the future.

The NHS Elective Care Programme Management approach would provide valuable learning, improve co-ordination with Pharmacy First and reduce regional variability.

Elective care recovery presents opportunities for community pharmacy to make use of Pharmacy First services to help with the backlog of clinical conditions appropriate for community pharmacy settings. Examples that have been quoted include otoscopy, ear wax removal, healthy living initiatives and NHS health checks.

Preventative services could be maximised through existing services such as Pharmacy First and expanding otoscopy, making better use of the hypertension case finding service and aligning diagnostic services to a Pharmacy First model of care. Pharmacy First would have to be expanded to align better with elective care recovery. This would be a move from Pharmacy First to **Pharmacy Forward.**

Conclusion

A review of the workflow for Pharmacy First needs to be undertaken to make sure pharmacy premises, consulting rooms and other referral services are fully optimised.

> **"There are many opportunities for England to work more closely with the UK Celtic Nations, integrating successful elements into its own system. By doing so, the NHS in England can potentially enhance the role of community pharmacies and improve overall healthcare delivery."**

Pharmacy First in England is a platform for success, which needs fine tuning and infrastructure changes to develop further.

The same diligent hard work that delivered Pharmacy First is now required to bring all stakeholders together – the pharmacy profession, IT services, primary care and health education – to create a new roadmap that will lead to a revised Pharmacy First service, moving to a model for England that is 'Pharmacy Forward'.

The views of pharmacy professionals in general practice on improving discharge medication information

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Introduction

Transitions of care (ToC) involving discharge from hospital are a recognised patient safety risk.[1] Medication discrepancies can happen at these transitions and there are recognised problems with the content of hospital discharge summaries, contributing to both patient harm, a poor discharge experience for patients, and a possible administrative burden for general practice in resolving any errors. For example, one systematic review found that one in two patients are affected by one or more unintentional medication discrepancies post discharge.[2] Among these patients affected by unintentional medication discrepancies, it was reported that between 25 and 34% of elderly patients, and 63.3% of paediatric patients were affected by moderate harm events.[2]

Within the United Kingdom a discharge summary, usually written by the admitting medical or surgical team doctor, provides details of the admission together with a prescription for the discharge medications. General Practitioners (GPs) view medication-related information to be one of a number of qualities that make up effective discharge communication from hospital to the community.[3] A qualitative study, undertaken at the time of the emergence of the new 'pharmacist in general practice' role, recommended for safer processing of discharge summaries that a primary care clinical team consider using a clinical pharmacist to assist with medicines reconciliation.[4] Pharmacy teams in general practice have an increasing role in processing discharge summaries.[5,6,7,8]

National electronic discharge standards stipulate that discharge summaries should include the details of and instructions for medications and medical equipment the patient is using. In addition, any changes to or discontinuations of medications current at the time of admission and any new medications to be continued after discharge, as well as reasons for all such amendments, should be documented.[9] Internationally, an Australian study identified, as one of a number of priority medicine handover issues and solutions, that patients must leave hospital with a discharge summary, including medication reconciliation information.[10] Others have gone further in suggesting guiding principles as to the content of a medication discharge plan (also known as a pharmaceutical care plan) at discharge.[11]

Within our hospital, pharmacists record changes to patient's medication in the electronic prescribing system during the inpatient stay and summarise these changes in a discharge medicines reconciliation (DMR) note.[12,13] This DMR note is included in the discharge summary which is transmitted electronically to the patient's GP, and a copy provided to the patient. The note and the list of discharge medications are also transmitted to the patient's nominated community pharmacy for the discharge medicines service.[14] There are approximately 2000 discharges a month from our hospital and the pharmacist team write about 1500 DMR notes per month.

This current study aimed to investigate the views of pharmacy professionals working in general practice on DMR notes written by the hospital pharmacy team, and to ascertain if the responses point to any opportunity for improving our DMR notes.

Methods

A cross-sectional study was conducted with pharmacists/pharmacy technicians in Cornwall general practice. Questions (mainly Likert scale) were developed with input from hospital pharmacists and pharmacists working in general practice. This survey was piloted with two practice-based pharmacy technicians, and no changes were made to the questions. Their responses are included in the results.

> "At the time of this study, there were 55 active general practices in Cornwall. The plan to undertake the survey was mentioned at a GP practice pharmacy forum meeting in June 2024. These networking meetings are run four times a year and designed to support pharmacists/pharmacy technicians in their GP practice or PCN work."

The study was conducted through an online questionnaire hosted online (Microsoft Forms). Emails with a link to the survey were sent out twice via a regular email message (Rx Shots) from the ICS Medicines Optimisation Team and three times via the forum network over late July/early August 2024. Completing the questionnaire online implicitly gave consent to participate in the survey. Descriptive analysis was performed in Microsoft Excel on responses to the closed, quantitative, questions. Free typed responses to the question 'Do you have any further comments you wish to make about how the hospital pharmacists can improve the DMR note process?', were analysed manually for major themes.

Results

After all mailings, 26 responses were received. From this total, 22 identified as female, and 4 as male. Participants were pharmacists (13), pharmacy technicians (12), and one trainee pharmacy technician, and their duration of working in a GP setting was 1-3 years for 10 respondents and less than 3 years for 16. Sixteen (62%) had a background of working in a hospital pharmacy department. At the time of the survey, 23 reported being employed by a primary care network (PCN) and three by a practice.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The DMR notes are generally useful in explaining medication changes that occurred during the admission	6 (23%)	16 (62%)	2 (8%)	1 (4%)	1 (4%)
The DMR notes generally provide additional information to the doctor-written discharge letter	4 (15%)	17 (65%)	2 (8%)	2 (8%)	1 (4%)
The DMR notes do not always fully explain the changes to medication that happened between admission and discharge	5 (19%)	19 (73%)	1 (4%)	1 (4%)	-
I do generally have trust in the reliability of these DMR notes	7 (27%)	13 (50%)	2 (8%)	4 (15%)	-
I wish more discharge letters were accompanied with DMR notes	19 (73%)	5 (19%)	1 (4%)	-	1 (4%)
In general I consider DMR notes to be up to date and relevant	5 (19%)	17 (65%)	2 (8%)	1 (4%)	1 (4%)
Sometimes DMR notes contradict other discharge information I receive	4 (15%)	17 (65%)	1 (4%)	4 (15%)	-
DMR notes should concentrate more on high-risk medicines and have less of a focus on short term/acute medicines, non-critical medicines	1 (4%)	5 (19%)	7 (27%)	10 (38%)	3 (12%)
I find the statement 'nil [other] deliberate changes to medicines' helps my processing of the discharge summary	11 (42%)	9 (35%)	4 (15%)	1 (4%)	1 (4%)

Table 1. Responses to survey questions n = 26

%s may not add to 100% due to rounding

When asked if they have a medicines reconciliation policy within their practice or PCN that covers how to manage discharge summaries, 20 replied yes and six replied no. Twelve pharmacists indicated that they had a prescribing role as part of their work. Of these, five strongly agreed and seven agreed that if their prescribing role required, they would make any necessary prescribing changes as prompted by the DMR notes.

Table 1 shows the responses to the various questions.

Free text comments were entered by 15 respondents. Major themes were around standardising the DMR notes (dated and with the name of the pharmacist who made the note); comprehensiveness of the notes (to cover off all medication changes); ensuring the notes are up to date at discharge; and a wish to have these notes accompany all discharge summaries if possible.

Discussion

The survey responses generally reflected a positive view of the DMR notes. When combining strongly agree with agree responses these notes are viewed as generally useful in explaining medication changes (by 85%), generally providing additional information to the discharge letter (80%), and trustworthy (by 77%). As regards the last point - trust in the reliability of the notes – this is again reflected in the view that all 12 pharmacist prescribers strongly agree or agree that they would make any necessary prescribing changes as prompted by the DMR notes. On this point of trust, we have not explored how the DMR notes are integrated with clinical judgment in pharmacy

teams (and the wider general practice), and how structured tools such as the DMR note interacts with professional expertise. We note also that 92% of respondents commented that the notes do not always fully explain changes. The proposal that such notes should concentrate more on high-risk medicines attracted a mixed response with only 23% supporting this. As expected, we found there is a wish to have more of these notes in the discharge summaries.

Though there is a substantial body of literature, both nationally and internationally, on how discharge summaries are processed in a general practice setting, there is limited evidence on how pharmacy professionals are actually, as opposed to potentially, involved in this process.[15] GPs in Ireland have said they particularly see a role for pharmacists in high-risk areas, for which they gave examples of hospital discharge prescriptions.[16] Whilst in an Australian study, general practice pharmacists expressed concerns over safety implications of undetected discrepancies due to recognition of incomplete medication information received in discharge communication.[17] Our small study was not intended to report on the actual activities undertaken by these professionals, but it does describe their views on how ToC could potentially be made safer by hospital pharmacy teams. Across Cornwall, general practice pharmacy personnel do have access to the e-Care system to view discharge summaries and DMR notes, and a small number of the free text comments reflected that these two sources of medication information do not always match up.

A similar process of the hospital pharmacy team adding notes to or annotating the discharge letter has been described elsewhere though these authors have not looked at how such notes are received in primary care.[18,19]

As a result of the survey feedback, we will consider wider roll out of a standardised DMR note template which our surgical team have recently introduced. This template reinforces the need for notes to be dated and have the pharmacist's name.

We recognise the limitations of receiving only 26 responses from possibly 90 pharmacy professionals working in these posts across Cornwall: a response rate of just under 30%. Hence, those who chose to respond may not be representative of the wider cohort. Furthermore, most respondents (16/26) had less than three years of experience in general practice, which may limit the generalisability of the findings. We utilised a self-administered survey as a cost-efficient method for obtaining response from a specific population. This method also provided anonymity and allowed participants to reply without being influenced by the interviewer's presence, so reducing response bias. We did not perform a reliability or validity assessment on the survey questions. As we describe, our DMR notes may also be viewed by community pharmacists as part of the discharge medicines service, and we have not sought their views on these notes.

Conclusion

The additional discharge notes made by the hospital pharmacy team describing medication changes that occurred during the hospital admission are generally well received by pharmacy professionals in general practice. There are however opportunities to improve the standardisation of these notes, and their comprehensiveness.

Acknowledgements

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The role of the clinical pharmacist in lipid optimisation in primary care: reflections from a secondary prevention project

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Summary

Frimley ICB undertook an ambitious project to support primary care in improving lipid optimisation for secondary prevention patients. The focus of the project was to change the mindset regarding statin monotherapy from a 'fire and forget approach' to one which offers a more bespoke model of patient care. Two specialist lipid pharmacists were appointed to provide intensive and tailored support to practices. These specialist pharmacists supported practice prescribers (including GPs, clinical pharmacists and nurse prescribers) with practical education, guidance on using search tools and support for delivering patient reviews. The specialist pharmacists also delivered clinical reviews themselves. The aim was to upskill staff through improving knowledge and confidence in lipid management, thereby improving lipid optimisation across the whole pathway.

The support offer was bespoke, with each practice choosing how they wished to utilise the time and skills of the specialist lipid pharmacists. This allowed the specialist lipid management pharmacists to gain unique insight into the support that primary care prescribers need to feel confident to optimise lipid management. The project was successful in shifting the dial on statin intensification with over 1700 patients being optimised on their lipid lowering therapy (LLT) over the course of the project and a further 973 being initiated on a statin. Practice feedback indicated that these services were greatly appreciated, particularly the opportunity for one-on-one education sessions focused around their specific patient population and mentoring throughout the project. In addition to the clinical outcomes, the project delivered interesting and useful findings on the role of the clinical pharmacist in primary care and the support they need to deliver excellent standards of long-term condition review.

Introduction

Cardiovascular disease (CVD) is a major cause of death and disability, causing 1 in 4 premature deaths in the UK (https://www.england.nhs.uk/ourwork/clinical-policy/cvd/). As such, preventing CVD is an important priority for NHS England. Central to CVD prevention is the management of cholesterol, specifically low-density lipoprotein cholesterol (LDL-C). LDL-C is well recognised as a significant and adjustable risk factor for CVD. Every 1 mmol/L reduction in LDL-C equates to a 22% reduction in major cardiovascular events.[1]

The vast majority of patients requiring LLT are managed in a primary care setting. For patients requiring LLT for secondary CVD prevention (i.e. people who have previously had a cardiovascular event) much of this work falls to practice or PCN pharmacists as part of routine long-term condition (LTC) reviews (https://www.longtermplan.nhs.uk/).

Frimley ICB wanted to improve the prescribing of LLT for patients with pre-existing CVD. Through engagement with frontline staff (formal meetings, anecdotal feedback and requests for education), the ICB medicines management and CVD teams recognised that primary care staff required support and education in order to improve confidence in optimising LLT. This was partly driven by the number of novel therapies for lipid lowering that have been introduced in recent years. A project was set up, delivered by two specialist lipid pharmacists who provided bespoke support, according to practice needs.

This project was established under the supervision of the ICB cardiac network and supported by the Medicines Optimisation Board.

Project delivery and learnings

During the development phase of the project the team spoke to staff working in primary care in order to understand the barriers to patients receiving optimum LLT. These conversations took place with individual practices as well as at CVD educational events and practice pharmacist meetings. Barriers were identified as:

- Poor coding, particularly of CVD
- Inconsistent systems in place to recall patients for repeat lipid profiles
- Lack of knowledge of search tools to identify patients who are sub-optimally managed
- Lack of primary care capacity
- "Fire and forget" perception around statin prescribing
- Lack of training to support the implementation of evidence-based practice
- Patient perception of statin side effects

For the project to be successful it was vital that the right support was provided to participating practices. The specialist pharmacists engaged in multiple meetings and forums across the Integrated Care Board (ICB), outlining the project and to understand the specific needs of each practice. It was clear that a traditional medicines optimisation project, consisting of searches and reviews would not fully address the challenges faced by primary care.

Therefore, from the start of the project, practices were able to build their own tailored solutions from a menu of options. Including:

- Training
- EMIS searches
- Desk-top reviews
- Face-to-face reviews
- Case discussion
- Joining a network of lipid champions within primary care

"Practices were also asked to identify a member of staff as a "lipid champion". This person was the key liaison point for the specialist pharmacists."

Training was offered at a practice level or in small groups 1:1. This enabled a focus on specific areas of challenge and allowed clinicians to explore issues in great depth. Training covered the following topics:

- Distinctions between primary and secondary prevention
- All aspects of lipid management including pharmacological treatments aligned to national guidelines
- Effective use of searches and tools like CVDPREVENT
- Considerations for chronic kidney disease including resources such as the renal database
- Making Every Contact Count (MECC) considering the ABCD of CVD (atrial fibrillation, blood pressure, cholesterol and diabetes)
- Taking a holistic approach including diet and lifestyle
- Counselling patients about lipid lowering therapy, particularly statin reluctance

To ensure a targeted approach, practice-level data slides were developed using national data sources, such as CVDPREVENT. These were discussed with prescribing staff in each practice (predominantly pharmacists but also nurses and GPs) to understand local needs and priorities. Training on utilising these national resources was provided, and practices were supported in running searches for patients with existing CVD who were not currently prescribed LLT. Specialist pharmacists conducted desk-top reviews of clinical records to assess the appropriateness of LLT for individual patients, including reviewing their indication for therapy, recent lab results, medical history, and comorbidities. This data was then summarised with patient-specific recommendations, which were discussed with the clinician leading the project within the practice. These discussions also served as educational opportunities, reinforcing the evidence-based rationale behind the recommendations. The clinical reviews with patients were carried out by both practice staff and the specialist pharmacists. Occasionally practice staff and specialist pharmacists carried out reviews jointly, which provided valuable learning insights. In all cases practice staff were encouraged to discuss complex patients with the specialist pharmacists.

An iterative approach was taken and the project was piloted in two practices with different demographics before being adapted based on learnings from the pilots on what sort of educational support practices required.

What improvements did the project deliver?

The project resulted in a notable increase in the number of people with pre-existing CVD who were prescribed a statin. Throughout the one-year project, an additional 973 patients were prescribed a statin.

In addition:

- nearly 1700 additional patients were on an optimal dose of statin at project end, compared to project start
- An additional 4655 patients with CVD had a lipid profile requested, compared to the previous year
- An additional 1990 patients with CVD had achieved their lipid lowering target at project end, compared to project start

Feedback from practices

A simple survey was sent to practices, requesting feedback on the project. Practices welcomed the support from the specialist pharmacists and the ability to discuss complex cases with them:

"They have been an invaluable resource for guidance and support in managing the complexities for our patients."

Practices explained that they appreciated the educational support. Several respondents described how, having been upskilled themselves, they were now looking to spread the learning across the wider practice team:

"This has allowed be to take on more responsibility in my practice on an individual level but also share that responsibility and learning with other key members at this surgery."

Several respondents explained how the project had help them take a more planned and proactive approach towards lipid review:

"It has helped place an emphasis by introducing more planned lipid reviews as well as a greater focus towards lipid profiles during medication reviews."

Overall, it was clear that the intervention was successful in improving the confidence of the staff managing lipid optimisation in primary care.

Several responses mentioned how their confidence has improved since the intervention of the specialist pharmacists:

"They gave me the confidence to effectively optimise treatment for secondary prevention and they ensured I was equipped with valuable knowledge which I then passed on to my peers."

What can we learn from this?

Clinical pharmacists are increasingly given the task of managing long-term conditions in the primary care setting, including secondary prevention of cardiovascular disease. In carrying out this project on lipid management we found that this staff group, based on feedback, often felt isolated in their role and sometimes felt unsure of where to seek either peer support or expert advice. Staff involved in the project highlighted the need for clinical mentorship and education, beyond the typical educational programmes such as webinars. We also found that some staff expressed the need for greater clinical variation and stimulation as many of the long term condition reviews (and associated activities such as blood test ordering and review) became repetitive and laborious.

This project demonstrates the appetite for greater peer support and access to specialist advice for clinical staff carrying out long term condition reviews in primary care. Ways of providing this support could include:

- A PCN approach to long term condition reviews, encouraging collaboration between practices within a PCN
- Learning and sharing events, including case study discussions at PCN or locality level
- Increasing access to specialist advice on CVD prevention, for example through a GP with specialist interest (GPwSI) or better links to specialist Cardiovascular Pharmacists within the acute setting

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A Student Pharmacist's Journey: Passion, Purpose, and Aspirations

Student pharmacist Kanupriya Sachdeva reflects on her journey so far and hopes for the future

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Kanupriya is a postgraduate student at the University of Brighton, studying the Overseas Pharmacists' Assessment Programme, due to finish in June 2025.

She was born and raised in India where she is a qualified pharmacist, and she moved to the UK in 2021 to pursue her higher studies. Kanupriya's education in pharmacy from India and the UK, combined with her management studies in the UK, uniquely positions her to achieve her goal of contributing to WHO's mission of evolving global healthcare standards.

Her background provides her with insights into the pharmaceutical needs of developing countries like India and the advanced healthcare practices of the UK. This dual perspective enables her to bridge gaps between diverse healthcare systems, advocate for equitable policies, and lead strategic initiatives that promote accessibility, quality, and innovation in healthcare worldwide.

Entering the world of pharmacy is akin to stepping into a dynamic, multifaceted arena where science meets humanity. As a student pharmacist at the dawn of my career, I am both awed and inspired by the potential to make a tangible difference in people's lives. This is not merely a career path but a calling, one that demands dedication, curiosity, and an unwavering commitment to patient care.

The Spark: Why pharmacy?

My journey into pharmacy began with a fascination for science, particularly the interplay between biology and chemistry. Growing up, I was captivated by how medicines could transform lives—a tiny pill alleviating chronic pain or a precise dose of insulin managing diabetes. This marvel of modern science ignited my interest, but it was witnessing the profound impact pharmacists have on communities that solidified my decision.

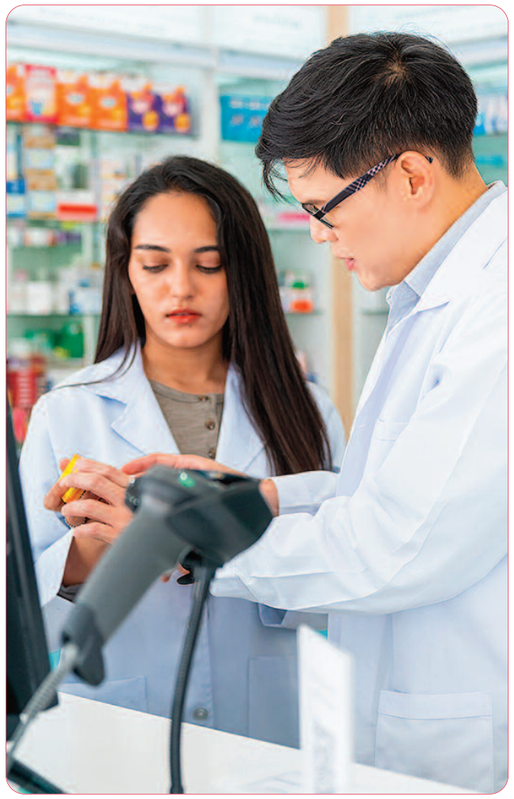
During my teenage years, a family member's health crisis brought me into close contact with a local pharmacist. Their role extended far beyond dispensing medications: they were a source of guidance, reassurance, and expertise. Observing their ability to bridge the gap between complex medical jargon and accessible patient education inspired me to pursue this profession. It was a realisation that pharmacists are not just custodians of medications but vital contributors to public health.

Areas of Interest: Carving my path

As I progress through my studies, several areas of pharmacy have captured my interest, each offering unique opportunities to contribute to healthcare:

1. **Clinical pharmacy:** I am particularly drawn to the clinical side of pharmacy, where collaboration with healthcare teams ensures optimal patient outcomes. The idea of tailoring treatment plans based on individual needs excites me, especially in managing chronic conditions like cardiovascular diseases or asthma.

2. **Pharmaceutical research and development:** Innovation drives progress, and the thought of contributing to the discovery of new drugs or improving existing formulations is deeply motivating. Advances in pharmacogenomics, for instance, hold immense potential for personalised medicine, and I am eager to explore this evolving field.



3. **Community pharmacy:** Community pharmacies serve as the first point of contact for many patients. The accessibility and trust placed in pharmacists in this setting resonate with my aspiration to foster strong patient relationships while promoting health and well-being.

4. **Global health and policy:** My interest also extends to the broader implications of pharmacy in addressing global health challenges. Access to essential medicines, combating antimicrobial resistance, and shaping healthcare policies are areas I hope to engage with as my career evolves.

A vision for the future

Looking ahead, my hopes are as ambitious as they are heartfelt. I envision a career where I can contribute to advancing pharmacy practice, ensuring it remains at the forefront of healthcare delivery. The integration of technology, such as artificial intelligence and telepharmacy, presents exciting avenues to enhance efficiency and accessibility—innovations I aspire to champion.

Equally important is my desire to remain grounded in patient care. Whether counselling a patient on managing side effects or explaining the importance of adherence to therapy, I aim to uphold the trust and responsibility that define our profession. Continuous learning will be a cornerstone of my journey, enabling me to adapt to the ever-changing landscape of medicine and healthcare.

Challenges and commitments

I am acutely aware of the challenges that lie ahead. The evolving healthcare environment, increasing complexity of medications, and pressures on resources demand resilience and adaptability. However, these challenges also present opportunities for growth. By embracing interprofessional collaboration, advocating for the profession, and prioritising patient-centered care, I am determined to navigate these hurdles with purpose.

A message to fellow practitioners

To the prescribers reading this journal, I offer my admiration for the pivotal role you play in healthcare. As a student pharmacist, I look forward to learning from your expertise and insights.

Together, we can continue to build a healthcare system where patient outcomes remain paramount, and every individual receives the care they deserve.

Conclusion

Pharmacy is a profession of infinite possibilities, blending science, compassion, and innovation. As I embark on this journey, my enthusiasm is fuelled by the promise of contributing to a healthier world. With guidance from seasoned professionals and the support of a robust healthcare community, I am optimistic about the future and the role I hope to play within it.

The road ahead is challenging, but it is one I am eager to travel. For me, pharmacy is not just a career, it is a profound opportunity to serve humanity, one patient at a time.

Prescription for equality: The role of secondary care pharmacy in bridging health gaps

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Introduction

Health inequalities remain a pressing issue, influencing healthcare strategies and shaping innovative approaches to care delivery. The terms 'inequality' or 'inequalities' appear 39 times in the *NHS Long Term Plan,* highlighting the critical importance of ensuring that the health system's goal of providing free healthcare at the point of use reaches the widest possible segments of society.[1,2]

Since 2000, every NHS strategy has consistently emphasised efforts to improve health and reduce inequalities.[3,4] This raises the pertinent question: is reducing health inequalities an achievable goal?

Advancements in technology and healthcare, coupled with external factors such as environmental, economic, and political influences, continually redefine the scope of achieving health equity. These factors profoundly shape the social and demographic composition of the population. For the NHS, mitigating avoidable disparities in health across different societal groups remains a significant challenge. Data from the Office for National Statistics (ONS) highlight between 2018 and 2020 showed an 18-year gap in healthy life expectancy between the most and least deprived areas (Figure 1).[5,6]

As the demand for NHS services continues to rise, the need for greater efficiency and innovation becomes increasingly critical to maximising outcomes from limited resources. Health inequalities, driven by socioeconomic factors,

Figure 1. Life expectancy at birth, England, 2018 to 2020.[6]

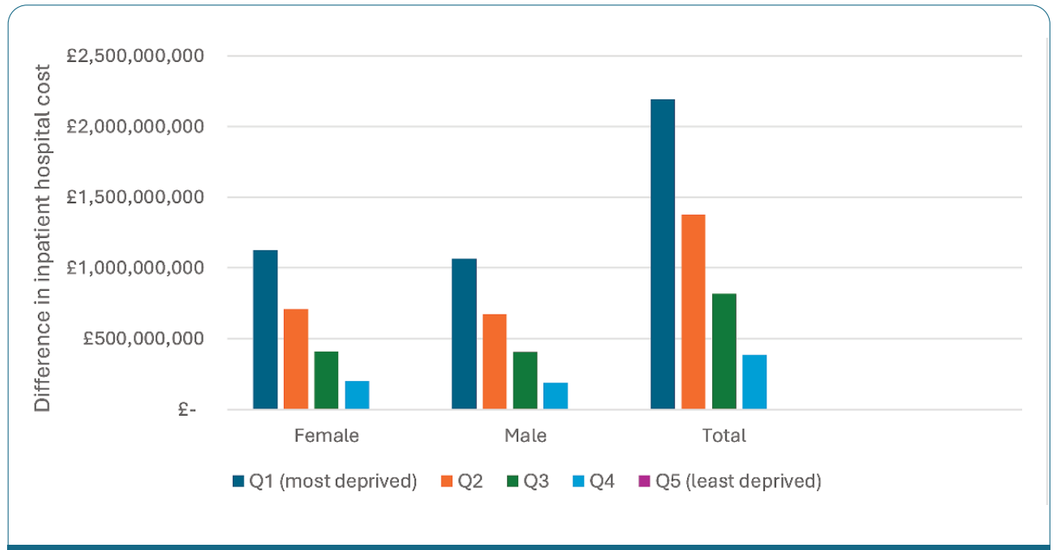

Figure 2. Difference in inpatient hospital costs by deprivation scale.[7]

burden the NHS with an estimated £4.8 billion in annual hospitalisation costs—highlighting the urgent need for targeted interventions to reduce this financial strain.[7] (Figure 2). Fully utilising multidisciplinary teams is crucial to improving health outcomes in a cost-effective manner, and pharmacists in secondary care have a pivotal role to play.

Determinants of health and why they matter

Ethnic minorities are disproportionately affected by deprivation, often living in low-income households, residing in overcrowded homes, and exhibiting poorer levels of health literacy.[8] Consequently, deprived populations face a higher burden of chronic illnesses such as respiratory diseases, cardiovascular diseases, and diabetes.[9]

The rising prevalence of comorbidities, particularly among socioeconomically disadvantaged groups, underscores the urgent need for efficient care and medicines optimisation. For example, lower socioeconomic groups experience higher rates of obesity, hypertension, and diabetes, which in turn lead to increased cardiac events in both sexes.[10] Complex risk factors—such as socioeconomic deprivation, comorbidities like diabetes and hypertension, and poor health literacy—intertwine to exacerbate health disparities, creating multifaceted challenges for equitable healthcare delivery. Patients from the most deprived backgrounds not only exhibit the highest cumulative expected lifetime healthcare costs but also suffer the lowest survival rates (Figure 3).

> **"Improving health outcomes yields benefits beyond individual quality of life, extending to significant societal advantages, such as increased productivity. "**

Prior to COVID-19, health inequalities were associated with £31 billion in lost productivity annually.[12]

Health inequalities represent a persistent challenge, influencing both strategic initiatives and operational priorities in healthcare. With the *NHS Long Term Plan* underscoring the need to address these disparities, the role of pharmacists in secondary care is increasingly critical.[1] As medicines experts, pharmacists are uniquely positioned to significantly impact health inequalities through clinical, educational, and advocacy roles.

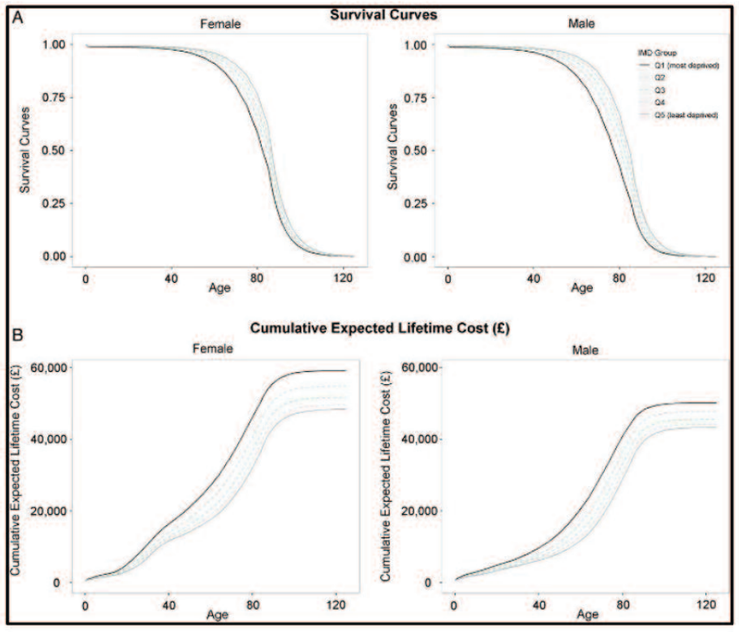

Figure 3. Survival curves and cumulative costs split by age, sex and deprivation.[11]

Invest to save using pharmacists

Secondary care pharmacists are uniquely positioned to bridge healthcare gaps, using their expertise in medication optimisation to improve outcomes for vulnerable populations. The Royal Pharmaceutical Society (RPS) emphasises that accessible pharmaceutical care is fundamental to reducing disparities.[13]

Tailored pharmacist-led interventions, such as medicines reviews, have demonstrated success in reducing hospital readmissions, particularly among socioeconomically disadvantaged patients who often face challenges with medication adherence.[14] Patients with chronic conditions, including diabetes and cardiovascular disease, benefit significantly from these targeted reviews, improving long-term outcomes and reducing acute care episodes.

Case study:

Leeds Teaching Hospitals NHS Trust (LTHT) developed a post-myocardial infarction clinic as a 'one-stop shop' for analysing key risk factors or markers, post-MI secondary prevention, diabetes management and management of other relevant comorbidities. This initiative optimised medicines for high-risk, comorbid patients, significantly reducing waiting times and improving adherence to secondary prevention therapies by 43–71%.[14]

The introduction of independent prescribing roles, supported by NHS England funding, has enhanced pharmacists' contributions to multidisciplinary teams. Independent prescribers improve access to care, reduce waiting lists, and provide new pathways for managing patients with complex needs.[15] However, the utilisation of pharmacists in secondary care remains inconsistent. While primary care has embraced the Additional Roles Reimbursement Scheme (ARRS) to integrate pharmacists into multidisciplinary teams, secondary care lags in this respect.[16]

A striking example is the underutilisation of specialist pharmacists in hospital trusts. For instance, only one in three hospital trusts in England employs a specialist diabetes pharmacist, and fewer than one in eight trusts have a full-time dedicated diabetes pharmacist, despite 10% of the NHS budget being spent on diabetes care and its complications.[17,18] This underinvestment represents

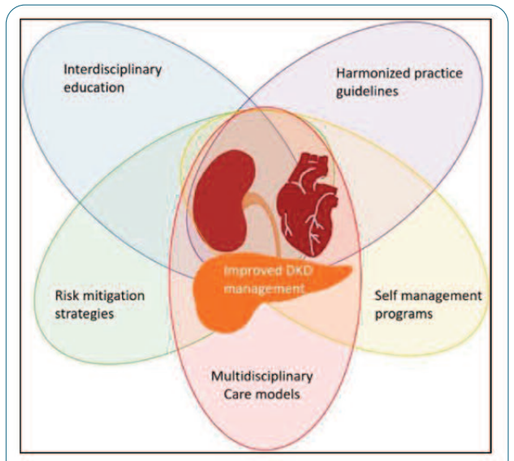

Figure 4. Compounds of a successful cardio-renal-metabolic care model.[20]

primary care increasingly relies on pharmacists to manage chronic conditions.

The prevalence of multimorbidity is projected to rise substantially in the coming years.[19] Patient-centred care models, such as cardio-renal-metabolic clinics, have been established in parts of England to manage high-risk patients; however, their uptake in secondary care remains limited. Combining management for these overlapping disease states under a unified service could prove more cost-effective and result in better health outcomes compared to traditional siloed care models.[20]

Enhanced access to pharmacists' unique skillsets—such as expertise in medication reviews, disease management, and patient education—could justify further investment in pharmacy services, expanding capacity while improving cost efficiency.

"Low socioeconomic status significantly contributes to missed appointments, often due to barriers such as inadequate transportation, inconvenient scheduling, or income loss.[22]

These challenges, combined with a higher risk of adverse health outcomes, underscore the urgency for expanding integrated multimorbidity services within secondary care.

Low-income patients often miss appointments due to transportation barriers, inconvenient scheduling, or potential income loss, underscoring the need for accessible and flexible healthcare services.[21] Coupled with the increased risk of adverse outcomes this further highlights the need for wider use of integrated or multimorbidity services in secondary care.

Within inpatient care pharmacists play a key role in medicines optimisation and future admission avoidance. One way this is done is by ensuring that patients are discharged with adequate medicines supply to allow primary care time to reconcile medicines and continue prescribing where

appropriate. Collaborating with social services and community organisations enables the provision of comprehensive care that extends beyond medical treatment, thereby addressing the root causes of health disparities. One such way to do this is greater involvement of pharmacy teams in multidisciplinary discharge rounds focused on long stay or medically fit patients awaiting care packages or discharges to community services to ensure that patients are supplied with their medicines prior to the day of expected discharge as a means of improving patient flow. This reduces the likelihood of errors providing a better opportunity for counselling or education about their medicines, particularly for those with complex regimens or low health literacy. This ensures patients are equipped with the knowledge and confidence to manage their medications effectively, reducing the risk of non-adherence, medication errors, and subsequent readmissions.

Bridging the gap between primary care and secondary care

Streamlined communication across primary and secondary care is vital for patient-centred healthcare, especially for vulnerable groups who often face barriers to continuity of care. Despite efforts like the Discharge Medicines Service (DMS) to improve integration, formal collaboration between primary care, secondary care, and community pharmacy remains limited. Gaps in care, particularly for vulnerable populations, could be mitigated through shared communication platforms, electronic health records, or medication reconciliation tools.

Cultural beliefs and language barriers

Language barriers and cultural beliefs present significant challenges to delivering effective healthcare in secondary care settings. When patients are unable to understand medical information due to language differences, the quality of care is compromised, leading to miscommunication, improper medication use, and poor adherence to follow-up care.[23] While professional interpreters can enhance communication and improve clinical outcomes, access to interpreters is often limited. Furthermore, language barriers persist beyond consultations, as patients may struggle to comprehend clinic letters, medication instructions, or health education materials. These challenges exacerbate health disparities and can have severe consequences for patient outcomes.

Patients' cultural beliefs significantly influence their understanding of illness and engagement with healthcare systems, underscoring the need for culturally sensitive approaches to care. For instance, cultural norms may discourage individuals from seeking timely medical attention due to stigma or a preference for traditional healing practices, resulting in delayed diagnosis and treatment.[24] Differences in expectations regarding care can further lead to dissatisfaction and disengagement, highlighting the importance of culturally tailored communication and trust-building efforts.[25]

Research underscores the value of culturally competent healthcare in addressing these barriers. Cultural competence involves understanding and respecting patients' cultural backgrounds, beliefs, and values, and incorporating this awareness into clinical practice. Training healthcare professionals to navigate these complexities has been shown to improve patient outcomes.[26,27] While the NHS has taken steps to educate healthcare professionals on the importance of ethnicity, diversity, and inclusion, there is a pressing need for a stronger focus on how these efforts translate into better patient outcomes. Embedding training on health inequalities and their determinants into standard practice can equip clinicians with a deeper understanding of the challenges faced by diverse populations, fostering empathy and building trust with patients.

Innovative solutions, such as Written Medicine, demonstrate how practical tools can bridge communication gaps and reduce health inequalities. By providing bilingual medicine labels, these tools help patients overcome language barriers and improve their understanding of treatment regimens, enhancing medication adherence.[28] Such initiatives are a vital step toward creating a more inclusive and effective healthcare system.

Bringing it all together

The NHS faces significant challenges as it recovers from the financial and operational impacts of the COVID-19 pandemic.[29] Among its priorities for 2024/2025 are prevention and addressing health inequalities, with a particular focus on enhancing the detection and treatment of conditions such as hypertension and hyperlipidaemia. Despite these efforts, the most vulnerable populations remain disproportionately at risk of developing multimorbidity. This underscores the urgent need for healthcare organisations to fully recognise the expertise of pharmacists and invest in diversifying the multidisciplinary team to include integrated pharmacist input.

Investing in collaboration at both technological and workforce levels would enhance the transfer of information between primary and secondary care, minimising delays in treatment and improving continuity of care. By integrating access to shared health records, the NHS can strengthen the connection between care sectors, enabling a more cohesive and patient-centred approach to addressing healthcare needs.[14]

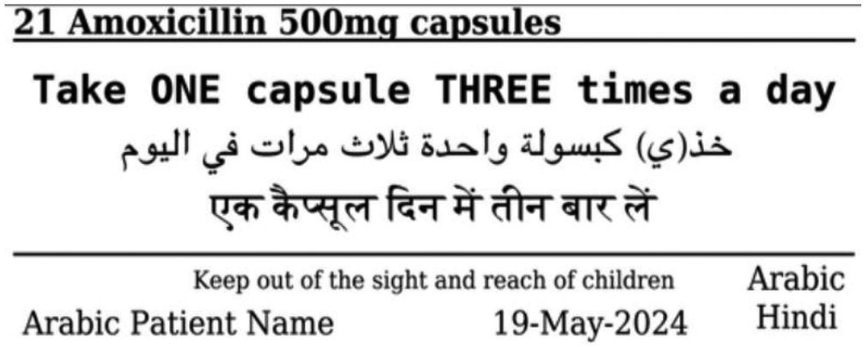

Figure 5. Example of a bilingual medicines label by Written Medicines.[28]

Implications for Practice: Practical Tips for Secondary Care Pharmacists

Identifying Health Inequalities in Practice

Pharmacists are well-placed to address health inequalities by systematically reviewing patient data to identify trends, such as frequent missed appointments, poor medication adherence, or disproportionate adverse health outcomes in specific demographics. Identifying barriers to healthcare access—such as language difficulties, low health literacy, or challenges navigating healthcare systems—is essential. Valuable insights can also be gathered from patient feedback, consultation audits, and multidisciplinary team discussions to better understand disparities in outcomes and target interventions within the local population.

Engaging Effectively with Vulnerable Populations

Engaging vulnerable populations begins with culturally competent communication. Pharmacists should adopt plain language, leverage professional interpreters, and utilise culturally relevant materials to ensure patients clearly understand their treatment plans. Personalised care plans, tailored to patients' socioeconomic contexts, cultural backgrounds, and health literacy levels, are crucial to overcoming barriers to care.

Collaboration with social workers, primary care providers, and community organisations is essential to addressing non-medical determinants of health, such as housing instability or financial insecurity. Pharmacists can also lead outreach initiatives, educating underserved populations on medication use and chronic disease management. By fostering trust and engagement, these efforts can significantly improve outcomes for vulnerable groups.

Advocacy and Action

Pharmacists can advocate for policies that prioritise equitable access to medications, healthcare services, and resources. Embedding these equitable practices into everyday workflows enables secondary care pharmacists to play a vital role in reducing disparities and delivering high-quality care to all patients.

Conclusion

Addressing health inequalities demands a comprehensive approach that fully utilises the expertise of secondary care pharmacists. By identifying disparities in patient outcomes and implementing tailored interventions, pharmacists can drive meaningful improvements in health equity. Collaborative teamwork, investment in integrated care models, and innovative tools like bilingual medication labels from Written Medicine are vital in breaking down barriers to healthcare access.

> **"Empathy-driven communication and culturally competent practices are crucial in fostering trust and engagement with socioeconomically disadvantaged and ethnically diverse groups."**

Additionally, improving integration between primary and secondary care systems through shared health records and streamlined workflows enhances continuity of care, minimises delays, and improves patient outcomes.

Expanding the role of pharmacists in multidisciplinary teams offers a practical and cost-effective solution to managing multimorbidity and chronic conditions, helping the NHS navigate increasing demands and financial constraints. Leveraging their skills in medication optimisation, patient education, and advocacy, pharmacists can help drive measurable improvements in both care quality and system efficiency.

Ultimately, reducing health inequalities is both an ethical responsibility and an economic necessity. Achieving this goal requires sustained investment, a commitment to collaboration, and a steadfast focus on patient-centred care. With targeted strategies and innovative solutions, secondary care pharmacists can play a transformative role in bridging care gaps and creating a more equitable and effective healthcare system.

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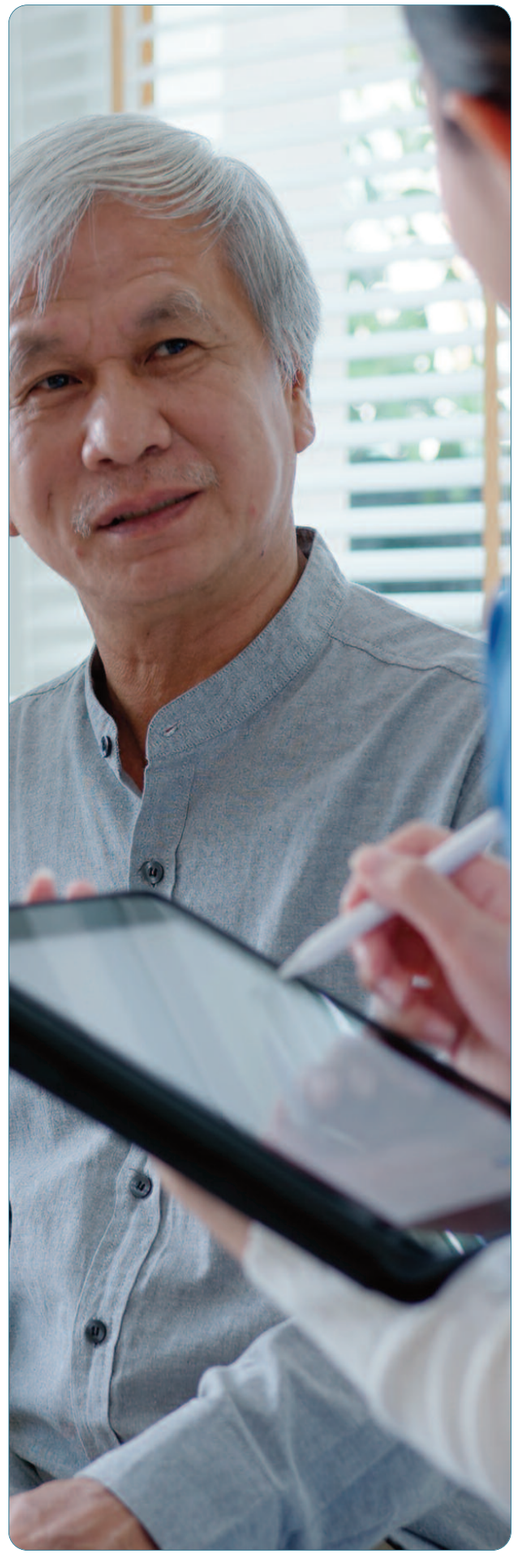

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Digital Solutions in Homecare

Personal Homecare Pharmacy shares its experience of developing and implementing an innovative digital solution to the delivery of homecare

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- Royal Pharmaceutical Society (RPS).

What is homecare?

The Royal Pharmaceutical Society (RPS) defines homecare medicine services as:

'A service that delivers ongoing medicine supplies and, where necessary, associated care, initiated by the hospital prescriber, direct to the patient's home with their consent'.[1]

This includes dispensing and delivery of medicines to patients' homes, as well as the processing and management of prescriptions. Patients on homecare services usually have a long-term condition (not exclusive) and are often on treatment with a high-cost medicine, requiring cold chain storage and transportation. In addition, clinical support can be provided to help patients self-administer treatment, or to have treatment administered to them in their home.

> "Clinical homecare pathways are agreed with the NHS and NHS England's Medicines Procurement Supply Chain (MPSC) and the National Homecare Medicines Committee."

A House of Lords Public Services Committee report on homecare medicines stated that the UK homecare market is not fully understood and is an opportunity lost. It also stated that homecare medicines services have significant potential to deliver high-quality care to patients in their homes and reduce pressure on NHS hospitals.[2]

Identified benefits of the homecare model include:[4]

- 62% of people receiving clinical homecare reported that it has allowed them to stay in work or education.
- 75,000 clinical homecare patients avoid a 40-mile round trip with each delivery, mitigating geographical inequalities and burden.
- 85% of clinical homecare patients are more likely to report that their medicines were fully explained to them, compared to the national average of 62%.
- £264m represents the annual value delivered to the UK health economy – delivered through operational savings, enhanced patient experience, and societal benefits.
- 15 NHS trusts' worth of day case elective capacity is delivered each year by clinical homecare companies.

- Contributing to tackling medicines wastage. Currently, 50% of people with a chronic disease do not take medication as prescribed[6] at an estimated cost of NHS around £300m every year.[7]

Digital innovation and homecare

The National Homecare Medicines Society (NHMC) Digital Subgroup was established to support the delivery of digital homecare.[3] It is clear that 'digital' has a significant role to play in sustainability and transformation, including delivering homecare medicines services at scale, enabling new service models and transforming care in line with NHS strategic and clinical priorities.

The NHMC report, 'System-wide Delivery of Medicines Homecare Output' shows that investment in an interoperable IT solution is needed to:

- Improve treatment outcomes.
- Increase patient independence and experience.
- Make time and economic savings for all (patients, NHS and homecare providers) through increased efficiency and productivity.
- Manage future growth.
- Improve governance and accountability.
- Ensure sustainability and transformation in line with national digital standards.

However, there is currently no system that is widely adopted which enables the electronic transmission of prescriptions between the acute trust prescribing system and the homecare provider.

Limitations of the current homecare delivery system

- There is limited homecare functionality built in within ePMA systems.
- For some trusts, there is zero or minimal electronic prescribing functionality and extensive use of paper prescribing for homecare.
- There are several variations in the way trusts produce and process paper prescriptions, which can include a mixture of individual homecare provider templates (therapy specific), trust prescription templates, or both, or printed paper prescriptions from their ePMA systems.
- Paper copy prescriptions are delivered by hand to pharmacies. Regardless of format within the trust (paper/digital), the homecare provider will

not release medications without an ink signature on the prescription.

- Prescription durations can vary significantly depending on the service/therapy and the items currently prescribed via homecare including prescription only medicines (POMs) and controlled medicines (CM). There may also be some requirement for general sale list (GSL) or pharmacy (P) medicines as supportive care.
- Some homecare prescriptions can also provide the functionality for the ordering of ancillary items and nursing services are detailed on a patients registration form.
- Additional information such as allergies and pharmacy clinical checks are annotated onto the paper prescription by hand, especially where electronic prescribing is not available. Clinical validation of the prescription normally occurs by a suitably trained pharmacist. As reported in the NHS benchmarking data 2019,[3] not all homecare prescriptions are clinically validated and therefore are not compliant with the RPS standards.

NHS challenges and homecare solutions

An estimated 6.8 million people are living with a health condition that could be appropriate for clinical homecare.[4] In response, the sector has been growing consistently at over 20% year-on-year (currently, over 600,000 people are receiving clinical homecare services across the UK[4]). Positive changes to the industry and healthcare systems could contribute to the further growth of the sector.

Clinical homecare is often associated with high-cost drug treatments, which accounts for around £4.2bn or 30% of the NHS secondary care medicines budget.[5] This would rise to 60% if extended to all medicines known to be suitable for homecare.[5] Efficiencies and improvements in homecare delivery would mitigate drug expenditure.

The NHS has clear ambitions to improve equity of access, enhance patient experience and improve efficiency. Combining clinical resources, geographical reach, medicines supply management and significant value for money, clinical homecare offers a novel alternative to traditional healthcare delivery across current patient pathways.

An NHS objective (stated in many policy initiatives) is to ensure patients receive care closer to home. Extending the use of clinical homecare services to treat patients in community settings supports this objective and will contribute to relieving pressure and footfall in NHS hospitals across the UK.

The homecare industry has the potential to transform how care is delivered, with significant benefits for patients, the NHS and society.[4] It is well placed to work closely with all key stakeholders including patients, the NHS and the pharmaceutical industry to achieve improvement objectives.

An innovative digital solution to homecare delivery

The provision of homecare services is often complex and difficult to deliver, and a significant factor is a lack of digital innovation within the sector. To improve digital service provision, the House of Lords recommended a single homecare portal to be created and linked to services such as the NHS APP.[2] It also stated that more urgency is required in developing electronic prescription systems for homecare providers to use. These should be developed in collaboration with homecare providers and the NHS.

> **"Personal Homecare Pharmacy (PHP) works within the UK clinical homecare market, providing a service to patients and the NHS that is safe, effective and valued. Operating within the homecare market has enabled us to realise that new solutions are rapidly required to drive much needed efficiencies."**

To identify solutions, PHP assembled a detailed project team to consider a range of potential alternatives, along with key considerations that could form part of an in-house improvement plan. The decision was to adopt a proven technology from another sector to solve challenges in the homecare pharmacy pathway. The project team

determined that an e-commerce platform could be utilised to provide the required solution. The team then determined which platform and partners it could collaborate with to create a solution that satisfied budgetary and time constraints.

We identified a partner company and then moved to implementation utilising an e-commerce platform managed by Adobe called Magento 2 (an open-source platform) to test various solutions in the homecare market. Use of the platform provided us and the NHS with efficiencies across the operational homecare pathway, while opening the potential for improved patient experience and outcomes.

A solution of this nature – repurposing existing technology – had not previously been fully realised in clinical homecare. Repurposing allowed for reduced development time, investment and risk – critical elements for any organisation. The technology adopted was able to provide real-time data to clinicians, choice to patients, and improved pharmacy working practices.

Description of the new service

Dispensing and delivering high-cost complex medicines is labour-intensive, complex and costly to deliver. The innovations implemented, using novel software, has enabled greater visibility of the many disparate processes involved. It has also improved processes for the NHS.

Our solution was to design and develop two new client-facing portals – one serving patients and one for NHS partners. This was welcomed by patients, the NHS and our pharmaceutical manufacturers, who largely fund the service supporting the provision of homecare.[8]

The new system has enabled a complete view of the patient service pathway from within a bespoke single coordinated system called Verum. This software has improved efficiency by giving greater flexibility for patients to manage their own service, as well as improving patient safety by reducing error rates.

Multiple systems were replaced by the new portal, allowing the development of a modern 'retail-like' customer experience for patients – many of whom are used to efficient retail experiences in other sectors and now expect similar levels of efficiency to be offered within a healthcare environment.

> **"Procurement is a continuous process as new medicines are made available, and many patients are moved from secondary to primary care. We see the introduction of efficiencies and safe practice as a significant driver for improved service delivery."**

An innovative 'Pharmacy Labelling System' is now incorporated fully into our medication and logistics pathways, giving us the ability to manage our logistics solution to safely deliver the correct medication to each patient on time and in full.

The system also drives our inventory management, which includes stock rotation and batch expiry. These are essential components to meet regulatory requirements and to minimise costly medication wastage.

Our repurposing of the e-commerce platform has successfully integrated e-commerce features within the unique demands of the healthcare industry and provides advanced reporting which allows us to monitor our KPIs closely to identify trends and helps us to drive efficiencies in clinical practice. The platform's user-friendly setup further democratises access, empowering a broader range of healthcare companies to embrace digital solutions.

Identified benefits of the portal

The new portal provides a more flexible level of service provision where patients can contact PHP at any time, choosing a date, time and place to have medication delivered and medicinal waste collected.

"Speedy access to information and educational materials related to treatment and care is available. Additionally, the portal uses cost-effective technology to change the homecare pharmacy landscape, allowing patients to receive their medication faster than the traditional pathway."

The portal works in real-time, increasing transparency and improving access to accurate information promptly. Each commissioning trust can see their patients' medication dispensing/delivery and invoice details in one secure place, including the delivery status of each patient.

The next development in the NHS portal will help pharmacies and clinics to log into the portal to onboard new patients in real-time – improving the speed of patient referral and access to medication for patients. This avoids manual transfer of data and validation issues, loss of materials, and contributes to reducing overall carbon footprint. Clinics can review and amend details of any patient/order and deal with issues or queries efficiently. RxESH and iQemo are both used, allowing prescriptions to be sent electronically, without a wet signature.

The portal is also designed to help the NHS manage the prescription renewal process for all patients on homecare, particularly a 'live' overdue prescription portal that allows trust users to see upcoming prescription renewals.

Results from the initiative

Results suggest that patients enjoy the service because they can contact PHP at any time day or night, providing them with the flexibility of choosing a delivery date for medication suited to their needs. Patients can also access the secure portal remotely, via a mobile phone or computer, without having to download an App.

PHP is currently working to conduct a more in-depth patient survey to further evaluate the service. In the interim in 2023, 8,147 patients chose to use the portal. This increased to 12,591 active patients (in May 24). In total, 25,646 patients have accessed the portal whilst they were on the service. Despite the portal being relatively new, 12 NHS hospitals have adopted it and a further 11 trusts are at the contracting stage.

The future

The introduction of the new platform is supporting patients and the NHS by offering efficiencies across operational pathways and opening the potential for improved patient outcomes. The technology provides real-time data to clinicians and patients and improves pharmacy working practices in the NHS and homecare sector.

Experience in the sector allows us to understand the changes that are required, and we are committed to further collaboration on a wider scale with the NHS to provide solutions that will ultimately bring care closer to home for patients across the UK.

Feedback from the NHS

Raghu Mamullapally, *Lead Pharmacist – Homecare Services, Pharmacy Homecare, Queen Alexandra Hospital, Portsmouth.*

As a frequent user of the PHP Clinical Portal, I can confidently say that it has revolutionised how I interact with patient prescriptions and manage their care. This platform is a 'game-changer' in terms of accessibility and efficiency.

One of the standout benefits of the portal is its user-friendly interface. Navigating through patient records and prescription statuses is incredibly easy and intuitive. I no longer have to spend precious time deciphering complicated systems or searching through piles of paperwork to find the information I need.

With just a few clicks, I can access transparent information about prescription status and delivery schedules, allowing me to quickly stay on top of my patients' needs. Moreover, the portal's ability to provide real-time updates on prescription status and delivery schedules has been invaluable in streamlining patient care.

Overall, the portal has enhanced my workflow and improved the care I can provide for my patients. Its ease of use and transparent information have saved me countless hours of administrative work, allowing me to spend more time focusing on what truly matters – the well-being of my patients.

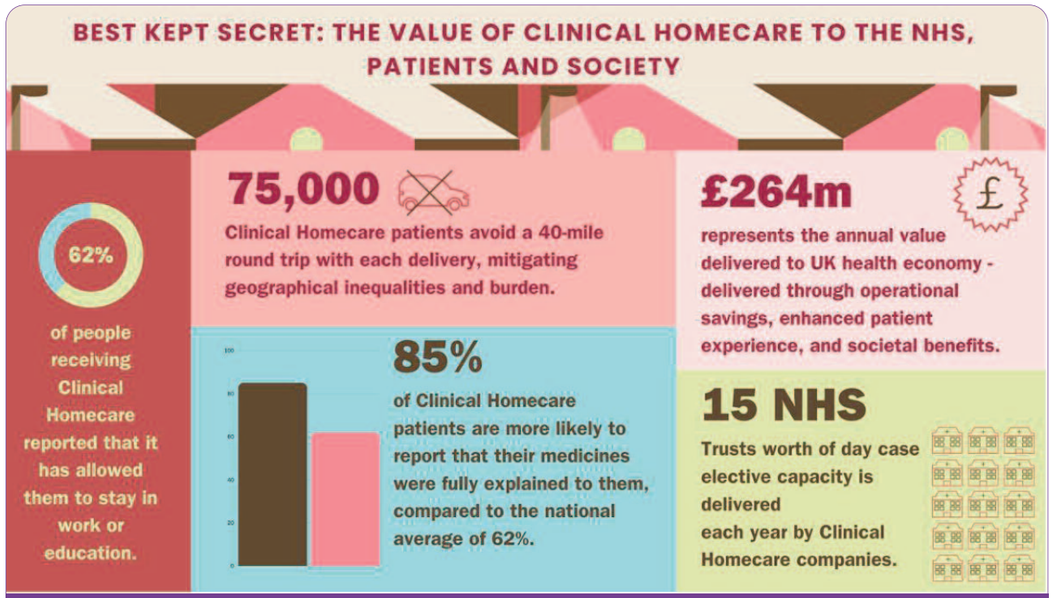
Patients	NHS	Society
1. Improved experience and personalised healthcare delivery 2. Reduced need to travel to appointments, allowing some people to work and retain independence 3. Improved geographical access, helping to tackle inequalities 4. Improved adherence to treatment 5. Safeguarding opportunities as a specialist clinical staff visits patients at home	1. Increased capacity by extending services outside of hospital 2. Financial savings and value 3. Reduced wastage and improved medicine adherence 4. Reduce do-not-attend rates 5. Improved medicines stock keeping and management 6. Improved patient satisfaction 7. Efficient switching of medicines – with significant financial benefits	1. Improved patient participation in employment and education 2. Reduced carbon emission and traffic congestion 3. Improved pharmacovigilance, supporting safe medicines for all.

Looking outside the market sector to explore tried and tested technology that has been used in other sectors and can be repurposed brings multiple advantages to the healthcare market, helping to keep research, development, and financial risk at a minimum, while maximising outcomes for the NHS. It also allows for speed to be brought to resolve some of the existing opportunities within the NHS and help free much-needed NHS resources.

Looking at previous research that is well documented by the Royal Pharmaceutical Society, the House of Lords Report and The Best Kept Secret: The Value of Clinical Homecare, the National Homecare Medicines Committee and the National Clinical Homecare Association,[1,2,4] we are well aligned within the marketplace to deliver much-needed improvement around the adoption of tried and tested technology to enhance the offerings and efficiencies that are needed in the provision of clinical homecare services.

Conclusion

Our initial research, findings and discussions with our clients – including patients, the NHS and pharmaceutical manufacturers – has informed us that digital innovation is essential and will address a gap within this market sector.



Extract from the Best Kept Secret: The Value of Clinical Homecare in the NHS, Patients and Society[4]

> "The solution that we have developed demonstrates that solutions can be scalable across the UK, within the NHS, while meeting the varying requirements of all stakeholders."

We acknowledge that real-world case studies are still in their infancy. However, we are very aware of the sectors that need to improve and adopt technological solutions and are driven to deliver the value that clinical homecare service provision is capable of providing to patients and the NHS. The report: *Best Kept Secret, The Value of Clinical Homecare to the NHS, Patients and Society*[4] showcases this value.

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