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Task 1 Healthcare service poster – Pharmacy service

1.explanation of the service

Community pharmacy services are a fundamental pillar of the NHS, acting as the most accessible front door to healthcare. Beyond simply dispensing prescriptions, modern pharmacies they do not require an appointment and are located directly within the heart of local communities. While their primary legal function is safe dispensing of medicines prescribed by doctors their role has expand significantly into clinical and public health domains.

Pharmacies provide a wide range of essential services:

- Clinical consultations: under the pharmacy first initiative pharmacist assess and treat seven common conditions (such as earaches, sore throat, and shingles) without the need for GP visits.
- Medicines optimisation: pharmacists ensure that patients particularly those with chronic conditions like asthma or hypertension understand how to take their medications to achieve the best health outcomes.
- Public health and prevention: This includes the delivery of the national flu vaccination programme COVID 19 boosters, smoking cessation support and emergency contraception.
- Urgent care support – pharmacies help divert minor injury and illness cases away from overstretched accident and Emergency (A&E) departments.

Brief history of service

The evolution of pharmacy in the uk is a journey from private retail chemist shop to highly regulated clinical hubs. Before 1948 inception of the NHS pharmacists often called apothecaries operated as independent businesses. Access to medical advice and medication was largely dependent on a patient's ability to pay.

When NHS was founded community pharmacies were integrated into the national system through a specific contractual framework. This ensured that lifesaving medication became a right for all citizens. A pivotal moment occurred in 1986 with the Nuffield report which concluded that pharmacists were an underutilised resource. This report triggered a decades long shift away from counting pills toward patient centred clinical care. In 2005 a new contract officially introduced "Advanced service" such as Medicine use reviews (MUR's) commenting the pharmacist's status as a clinical professional rather than a shopkeeper.

Current Functioning of the service

Today, pharmacy services function through a highly digitised intergraded network. The electronic prescription service (EPS) is the backbone of modern operations allowing GP to send prescriptions instantly to a patient's chosen pharmacy reducing errors and improving speed.

Pharmacies now operate within integrated care systems (ICS). This structural shift ensures that pharmacies are no longer silos but are connected to their wider healthcare team. For example, through the discharge medicine service when a patient like Mrs Mann is discharged from a hospital the hospital pharmacy sends a digital message to her community pharmacist. The community pharmacist then checks her new medication against her old records to prevent medication reconciliation errors which are leading cause of hospital readmission.

Two major challenges faced by the service

Challenge 1: Financial crisis and closures

The primary challenge is the current funding model. Approximately 90% of a community pharmacy income comes from the NHS but this funding has been effectively frozen for several years. With the rising costs of wholesale drugs, electricity, and wages many pharmacies are operating at a loss. This has led to a record number of permanent closures across the UK, particularly in deprived areas which reduces the public access to vital healthcare.

Challenge 2: Workforce shortages and Burnout

There is a critical shortage of pharmacist and pharmacy technicians. Many professionals are being recruited into GP surgeries or hospital roles, leaving companies pharmacies understaffed. This creates a high-pressure environment were existing staff face burnout. Shortages often lead to temporary closures of the prescription counter or longer waiting times which can compromise patient safety and the quality of care provided.

Task 2: The origins and structure of the national health service

The national Health service (NHS) was launched on July 5, 1948, by the then health secretary Aneurin Bevan. Its creation was the result of a massive societal shift following the Second World War. The blueprint for the NHS was found in the 1942 Beveridge Report, which argued that for the Britain to prosper the government had to slay the "Five giants" of social misery want, Disease ignorance squalor and Idleness, before 1948 healthcare was a luxury. Working class families often relied on a charity or simply went without treatment. The

NHS revolutionised British life by making healthcare a public service rather than a commercial product.

Key principles of the NHS

The NHS was established on three founding pillars that remain legally and ethically central to its mission:

1. **Universality:** The service is available to everyone, regardless of their background or status.
2. **Free at the point of delivery:** Access to doctors and hospitals does not require a fee the service is funded through general taxation.
3. **Based on clinical Need:** Treatment is prioritised based on how sick a person is not on their ability to pay or their insurance level.

Current structure and functioning

The modern NHS is no longer a single giant organisation but a complex system of many different bodies. It is split into commissioners who plan and buy the services and providers (who deliver the care).

The system is categorised into:

- **Primary care:** The first contact service including GP's, pharmacies, Dentists, and opticians.
- **Secondary care:** specialised services usually provided in hospitals such as surgery mental health service, and A&E.
- **Tertiary care:** Highly specialized treatment for rare conditions (eg, specialised cancer centres).

In recent years the structure has moved toward integrated care system (ICS). These are partnerships that bring together the NHS, local councils, and voluntary sectors to plan and deliver joined up care for their local populations. This structure aims to improve health outcomes by treating the person as a whole rather than just treating a single disease in isolation.

Critical Examination of functioning

While the NHS is a national treasure it is currently facing its greatest challenge since 1948. The functioning of the system is hindered by a growing aging population. Elderly patients often have multiple long-term conditions that require expensive long-term care. Furthermore, the system is struggling with a massive backlog of elective surgeries and high waiting times in emergency departments. While the shift toward integrated care is designed to fix these

issues by moving care out of hospitals and into the community the lack of investment in social care makes this transition difficult. The survival of the NHS depends on its ability to evolve from a national sick service that treats illness to a national health service that prevent it through and technology and community support. When hospitals beds are occupied by patients who no longer require acute medical intervention it prevents new patients from being admitted through Emergency departments. This leads to the record-breaking waiting times and ambulance handover delays currently seen across the UK furthermore the rising cost of living and a shortage of healthcare staff have exacerbated these pressures leading to widespread burnout this and strike actions within the workforce. While the 2022 move toward integrated care systems (ISC) aims to bridge this gap by uniting the NHS and local councils the success of this model depends entirely on increased investment in the social care workforce. Without resolving these underlying structural issues, the NHS remains a reactive system struggling to manage the demands of a 21st century population with a 20th century funding model.

References

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