



Exploring the role of pharmacist leadership in health inequality improvements

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07.05.2025





Introduction

- Worked in collaboration with the Community Care Collaborative and commissioned by BSOL Integrated Care Board through the Better Care Fund
- This project highlights how a pharmacist-led paediatric respiratory hub is transforming care for children with respiratory symptoms in Birmingham.





Our current context and what we are trying to achieve

The NHS is facing a number of challenges that we are seeking to tackle through our **Locality and Neighbourhood Health Service Model**



Challenges



Improve access to Primary & Urgent Care

What we are trying to achieve

Alleviate pressure on services and

support our staff to provide the care needed

Enhance patient experience and

clinical outcomes



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Shift activity to the most appropriate setting (i.e. from hospital to community)



Deliver more productive, efficient and financially sustainable care





Our Locality and Neighbourhood Health Service Model

- Childhood respiratory illness is a significant population health challenge and a key focus of the Core20PLUS5 framework.
- The West Birmingham Neighbourhood team have developed a new Clinical Pharmacist led Paediatric Asthma pathway, offering timely access to diagnostics such as FeNO testing and spirometry
- This approach supports earlier diagnosis, more accurate treatment, and reduced reliance on urgent care.







A New Patient Pathway

An integrated neighbourhood model that is improving early diagnosis, reducing unnecessary treatments, and delivering more effective care for children—while creating a scalable blueprint for systemwide impact.





Our Approach

- Risk stratification
- Personalised Approach
- Referrals from Primary Care and the Integrated Neighbourhood Team and Specialist Paediatric Respiratory nurse
- Feedback
- Service Refinement











Key Outcomes

The outcomes from this service indicate a significant impact on asthma diagnosis and management:

Asthma Diagnosis:

- ➢ 71% of patients received a confirmed diagnosis of asthma.
- > 5% had asthma excluded following assessment.
- > 33% remain under follow-up for further evaluation including trial of treatment.

Treatment Decisions:

- > All diagnosed patients were either stepped up on existing treatment or initiated on preventor therapy.
- Patients were discussed at a multidisciplinary team (MDT) meeting involving a specialist to support community delivery of care and avoiding hospital utilisation.





Patient Testimonial

"We want to sincerely thank you for the incredible care you gave our daughter.

For years, she was frequently hospitalised with "virus-induced asthma," but no one properly investigated her condition. Over the last 12 months she was hospitalised twice and missed many days of school due to her symptoms.

By chance, my sister mentioned her situation during her appointment with you, and you kindly agreed to see our daughter the same day. Within an hour, you identified severe airway inflammation with diagnostic tests and promptly prescribed her a preventer inhaler.

Since starting treatment, her life has changed completely—no more panic, chest pain, or sleepless nights. She can now enjoy school and childhood again, thanks to you.

Your expertise, kindness, and prompt action made all the difference. We are truly grateful."

BCF Metrics



KPIs will be aligned to the Better Care Fund metrics for the purposes of demonstrating impact



Please note:

The data shown below relates to Birmingham and Solihull residents (as per BCF reporting criteria) plus BSOL registrants' admissions at any hospital provider. Data shown is **SUS data** (as opposed to HES data used by BCF), so will be broadly similar to what is reported on the Better Care Exchange

BSOL resident population split:	Locality	Reg_
	West	
	South	
	North	
	Solihull	
	East	
	Central	

ACSC admissions by Primary Diagnosis														
Locality	Population	AFib	Anaemia	Angina	Asthma	CHF	COPD	Dementia	Diabetes	Epilepsy	НерВ	Hypertension	ACSC Total	ACSC per 100,000
North	282,049	319	259	33	401	176	858	29	290	192	1	82	2,640	936.0
East	274,502	181	266	13	575	110	589	21	299	228	1	67	2,350	856.1
Central	241,661	200	200	4	501	97	476	19	261	159		40	1,957	809.8
Solihull	237,216	300	164	6	317	124	538	30	162	159		56	1,856	782.4
South	303,461	251	154	12	427	119	749	21	313	166		30	2,242	738.8
West	271,847	117	142	14	376	96	263	24	230	125	1	38	1,426	524.6
Total	1,610,736	1368	1185	82	2,597	722	3,473	144	1555	1029	з	313	12,471	774.2

CSC admissions per condition as a proportion across each locality														
Locality	Population	% AFib	% Anaemia	% Angina	% Asthma	% CHF	% COPD	% Dementia	% Diabetes	% Epilepsy	% HepB	% Hypertension	% ACSC Total	ACSC per 100,000
North	282,049	23.3%	21.9%	40.2%	15.4%	24.4%	24.7%	20.1%	18.6%	18.7%	33.3%	26.2%	21.2%	936.0
East	274,502	13.2%	22.4%	15.9%	22.1%	15.2%	17.0%	14.6%	19.2%	22.2%	33.3%	21.4%	18.8%	856.1
Central	241,661	14.6%	16.9%	4.9%	19.3%	13.4%	13.7%	13.2%	16.8%	15.5%		12.8%	15.7%	809.8
Solihull	237,216	21.9%	13.8%	7.3%	12.2%	17.2%	15.5%	20.8%	10.4%	15.5%		17.9%	14.9%	782.4
South	303,461	18.3%	13.0%	14.6%	16.4%	16.5%	21.6%	14.6%	20.1%	16.1%		9.6%	18.0%	738.8
West	271,847	8.6%	12.0%	17.1%	14.5%	13.3%	7.6%	16.7%	14.8%	12.1%	33.3%	12.1%	11.4%	524.6
Total	1,610,736	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	774.2

ACSC admissions as a proportion across each Locality														
Locality	Population	% AFib	% Anaemia	% Angina	% Asthma	% CHF	% COPD	% Dementia	% Diabetes	% Epilepsy	% HepB	% Hypertension	% ACSC Total	ACSC per 100,000
North	282,049	12.1%	9.8%	1.3%	15.2%	6.7%	32.5%	1.1%	11.0%	7.3%	0.0%	3.1%	100%	936.0
East	274,502	7.7%	11.3%	0.6%	24.5%	4.7%	25.1%	0.9%	12.7%	9.7%	0.0%	2.9%	100%	856.1
Central	241,661	10.2%	10.2%	0.2%	25.6%	5.0%	24.3%	1.0%	13.3%	8.1%		2.0%	100%	809.8
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Thank You