

Working collaboratively in an ICS

Freeing up opportunities in community pharmacy

About

This report explores the opportunities for greater collaborative working between community pharmacy, primary care networks and federations within integrated care systems, and how barriers can be overcome.

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

As part of the NHS Confederation, the PCN Network and Primary Care Federation Network provide a strong national voice for primary care, representing the views of primary care networks and federations, supporting their development and influencing the national policy debate.

The National Pharmacy Association is the representative voice of independent community pharmacies across the UK. We provide a range of services, including learning and development for the whole pharmacy team, to help our members provide an excellent service to their patients and communities.

The Primary Care Pharmacy Association (PCPA) supports primary care pharmacists and pharmacy technicians through a network of leading practitioners, sharing best practice and inspiring innovation. PCPA's mission is to promote clinical excellence for the benefit of our patients, our members and our profession.

Contents

5 Key points

7 Background

9 Context

10 Moving forward

What are the opportunities for community pharmacy, PCNs and GP federations to work collaboratively with ICSs?

13 Removing barrier to progress

What is hindering collaboration and what needs to change?

17 Viewpoint

18 Appendix 1: Roundtable contributions

19 Appendix 2: Key actions for PCN clinical directors, leads and community pharmacists

Key points

- Community pharmacy is an integral part of the NHS and has a vital role to play as a full partner within a primary care network (PCN). Medicines' safety and optimisation are widely recognised as part of its unique skill set but, increasingly, community pharmacy is collaborating with partners in primary care to deliver integrated clinical services in integrated care systems (ICSs).
- In July 2021, leaders from leading pharmacy representative bodies, GP federations and PCNs took part in a roundtable discussion to highlight the opportunities that working collaboratively in an ICS has to offer, and to discuss solutions to current barriers.
- Participants identified seven key requirements to ensure that the opportunities and benefits of involving community pharmacy are realised. These requirements are relevant to: NHS leaders developing and implementing ICS guidance; community pharmacists who want to play their part in shaping new ways of working; partners working in general practice and in GP federations; and existing leaders in ICSs and PCNs.
 1. Community pharmacists must be given the time and space to get involved in working through the development of local services with their primary care colleagues.
 2. Community pharmacy and general practice need to work through the historical perceptions of their relationship as providers, moving from a position of competition to one of collaboration and a single voice for primary care.

3. To achieve change at scale, service developments must be translated into a national contract specification for local adoption with the ability for some local flexibility to be applied to meet the specific needs of a local population.
4. Nationally specified services should be properly resourced, recognising that commercial viability is a valid request by contractors in the NHS.
5. ICSs must support the implementation of nationally specified services, locally ensuring there is project management, IT deployment and system-level governance and oversight for implementation. This should be backed up with appropriate mechanisms to involve community pharmacy in decision-making at all levels and resources available to enable this.
6. An appropriate information technology and information governance framework is needed to support data sharing and facilitate the development of local services and the implementation of national services.
7. An appropriate medico/legal framework is needed which recognises the role of pharmacists as independent prescribers and resolves issues relating to conflicts of interest.

Background

The NHS has been working towards the implementation of integrated care systems (ICSs) for several years and recently there has been a move to solidify this way of working through statutory changes. In June 2021, the [ICS Design Framework](#) set out some of the detail of how NHS organisations should continue their journey towards an ICS and prepare for the new statutory arrangements. Central to the new arrangements is the concept of collaboration and partnership working at a local level; something which is strongly supported by the NHS Confederation and its membership. We were therefore delighted when the community pharmacy sector approached us to host a roundtable on ensuring that community pharmacy is effectively integrated in ICSs.

Working closely with the National Pharmacy Association, we brought together a group of leaders across community pharmacy, primary care networks (PCNs) and GP federations to discuss the opportunities of collaboration and to identify the key enablers available to local systems. We also explore some of the barriers and ideas for how they should be addressed. The roundtable was chaired by Dr Graham Jackson, GP and senior clinical adviser at the NHS Confederation, on 7 July 2021, the day after the new health and care bill was published. For a full list of contributors to the event, see Appendix 1.

This report highlights the key points from the discussion and is aimed at a range of NHS leaders, at local and national level, who are involved in developing and implementing guidance on how organisations are expected to operate with their partners in an ICS from April 2022. It is relevant to community pharmacists who want to play their part in shaping new ways of working; to their partners working in general practice and GP federations; and to existing leaders in PCNs.

In addition to the full report of the discussion, we have produced a briefing for PCNs and community pharmacists which highlights practical actions to deliver quick wins from integrated working with community pharmacy. The key actions from this briefing are set out in Appendix 2 and the full document is available on the [NHS Confederation website](#).

Context

The five-year [community pharmacy contractual framework \(CPCF\)](#), published in July 2019, set out a joint vision for the service which recognised the role that community pharmacists have to play in delivering clinical services. It set out a clear expectation of collaboration with PCNs and it revised funding arrangements for community pharmacy, to facilitate integrated delivery models. In essence it established community pharmacy as a full partner in PCNs with a clear role in urgent care, prevention and medicines optimisation, which in return required community pharmacists to collaborate not only with their partners but with each other, in a way that many had not been able to do so before.

Some PCN service developments, as anticipated in the CPCF, did not progress as planned, due in the main to the COVID-19 pandemic and the unprecedented impact it had on all partners in primary care. Conversely, the pandemic also accelerated collaborative working in some areas, with services coming together in creative ways to address the high level of need in communities. The key aspects of this are highlighted in our briefing [One Year On and One Pandemic Later](#).

With the NHS looking to the future as the health and care bill passes through parliament, we wanted to bring leaders in primary care together – from general practice and community pharmacy – to review the opportunities that exist now to release the benefits of integration enabled through the CPCF. And to examine what further change may be required to remove barriers to integration.

Moving forward

What are the opportunities for community pharmacy, PCNs and GP federations to work collaboratively with ICSs?

Participants in the roundtable discussion all welcomed the opportunities signalled in the ICS Design Framework. It was seen as an important mechanism to bring together both commissioners and providers in primary care in the same place to commission the whole patient pathway instead of in silos. This was seen as something where community pharmacy has a unique contribution to make because of its strong connection with local communities and the understanding of patient need that this brings, combined with a range of clinical skills that enable it to be the first port of call for a range of patient conditions.

“ Medicines will always follow the patient, so why do we not commission a pathway rather than commission in silos...I think the ICS framework will actually open that discussion up, and pharmacies will have an absolutely vital role in that, but we need to ensure that the voices and true advocacy [for the role community pharmacy can play] are being made at strategic boards and at provider boards.”

One participant pointed to the fact that commissioning via an ICS will allow alignments to the GP and community pharmacy contracts that already exist in a small way to be further enhanced, such as provision of flu vaccinations. It was stressed that the realisation of the current expectation that ICSs will be able to use

“the administratively efficient” route of commissioning community pharmacy at a local level without recourse to the NHS or local authority standard contract would be critical here as they are prohibitive for small locally developed services.

While the conversation was about benefits of minor contractual alignments and small local service change, all agreed that this was an important aspect of the reforms. These small local services have the ability to deliver a disproportionate benefit in terms of the positive impact on patient outcomes and improved working relationships between GPs and community pharmacists. Similarly, it was noted that the requirement to work together on practical changes, such as implementing a shared care record by April 2022, would be an important catalyst for system working across providers.

The potential and need for primary care providers to integrate with each other as well as with other sectors was a constant theme throughout the discussion. This was seen as a key mechanism for gaining a voice for primary care within the ICS and ensuring that, as stated in the ICS Design Framework, it is embedded in decision-making at all levels of the system.

“ We probably see GPs acting sometimes as a primary care soloist and really what we probably want to try and do is build a bit of a choir because we think if we bring in the voice of community pharmacy..., draw our colleagues in dental in and indeed our [optometry] colleagues as well, the stronger voice of primary care will be heard ... we are definitely stronger together and a better-balanced system will result at an ICS level if we draw together at scale rather than just equating general practice with primary care. ”

With respect to the clinical skills of community pharmacists, one participant drew attention to three ways in which these can be used for system benefit:

- Community pharmacy being seen as the optimum place to go to care for certain conditions.
- Community pharmacy being part of a clinical patient pathway, such as the Discharge Medicines Service, which is something that community pharmacists already provide with a potential to deliver system benefit in terms of reduced readmissions and occupied bed days.
- Community pharmacy as part of a clinical service delivery model, particularly in PCNs. For example, the delivery of hypertension case finding.

There was strong support for using the broader clinical skills of community pharmacists in this way. However, it was felt that medicines optimisation should be a golden thread running through the community pharmacy offer, particularly given the high level of NHS spend on medicines and the impact that community pharmacy can have on improving patient outcomes.

The integrating NHS pharmacy and medicines optimisation programme (IPMO) was highlighted here as a potential catalyst, although it was recognised that there is still a long way to go to in effectively harnessing the expertise of pharmacists to transform systems. The role of PCN pharmacists and practice pharmacists was welcomed, but the need to ensure that these roles draw community pharmacy towards providing patient care pathways, and not push them away, was emphasised.

Removing barriers to progress

What is hindering collaboration and what needs to change?

One participant, who is leading community pharmacy within an ICS, described “a lack of clarity at the ICS level and the locality level and indeed at neighbourhood level as to what community pharmacy can do”. This experience was echoed by others. GPs involved in the discussion acknowledged that their day-to-day relationships with community pharmacy are frequently driven by operational pressures and hence discussion is often limited to issues such as the availability of medicines. This has given rise to a position whereby services that are currently part of the CPCF are not universally known about or implemented.

It was acknowledged that this lack of clarity could be addressed if the pharmacy profession articulated what it could deliver in the context of the priorities of the commissioning body. It was agreed that to enable this to happen, it is vital for community pharmacy to be involved in the early stages in the ICS as it develops its priorities and associated commissioning framework.

To facilitate this involvement, there was a call for a consistent approach across an ICS, because of the complexities involved in responding to multiple ways of doing things. For example, one participant described the time-consuming process of working across various structures in the ICS to implement the Community Pharmacist Consultation Service, even though there is a national specification for it and it forms part of the CPCF. This gave rise to a comment from one participant about the importance of sorting the local implementation of nationally specified services. Without this,

community pharmacy will be constrained in its ability to add value in the way that has been intended nationally.

There were examples described of GP practices working collaboratively with their colleagues in community pharmacy to establish locally specified services, such as an early minor ailments scheme; community pharmacy leading the COVID-19 vaccination service; and exploration of the potential for primary care professionals outside of general practice to have direct access to a range of diagnostics. The ‘independents’ in the community pharmacy sector were described as particularly well placed to match the way in which general practice has traditionally responded to overcome “bureaucratic obstacles” to get new services up and running quickly.

However, it was recognised that there are issues of sustainability with respect to small-scale locally developed services. Some participants described how they had run into difficulties when it came to ensuring compliance with clinical and information governance requirements. This can be particularly problematic for larger community providers that have national and, in some cases, international company policies that they must adhere to.

One participant described how the approach of national specification for local adoption would assist larger community pharmacy providers to respond at scale; the way that the COVID-19 vaccination programme had been taken up by community pharmacy being one example of this.

One interpretation of the discussion was that services developed locally on a small scale have a place in integrated and collaborative working, as they foster innovation and can be the vehicle for providing proof of concept and building relations across primary care professionals at grassroots level. There are three ways in which these innovative services can be supported to develop:

- Community pharmacists must be given the time and space to get involved in working through the development of local services with their primary care colleagues.
- Community pharmacy and general practice need to work through the historical perceptions of their relationship as providers, moving from a position of competition to one of collaboration. Participants at the roundtable believed there to be mutual benefit in this approach, for patients, individual contractors and primary care as a whole.
- A national specification for information governance/local health records is needed as this is a common obstacle to integrated working.

For these innovative services to have an 'at scale' impact, there was agreement that they must:

- be translated into a national contract specification for local adoption, with the ability for some local flexibility to be applied to meet the specific needs of a local population
- be properly resourced, recognising that commercial viability is a valid expectation for contractors in the NHS and good economic principles need to be applied to commissioning.
- be effectively communicated to the ICS and appropriately supported around implementation, with appropriate mechanisms in place for community pharmacy involvement in decision-making at all levels and resources available to enable this
- have the appropriate information technology and information governance in place to support necessary data flows, backed up by an environment of trust across the clinical professionals who are writing and reading the shared record

- have an appropriate medico/legal framework in place which recognises the role of pharmacists as independent prescribers and resolves issues relating to conflicts of interest.

Finally, the group challenged each other to ensure that where there are already national services in place, work to implement them at local level must be prioritised. While it is recognised that community pharmacy has finite resources, there is an ability to harness additional capacity in response to plans to extend the range of clinical services that it delivers.

Two services were highlighted as ones that are part of the CPCF and relevant to every system because of the proven impact on outcomes for patients, reduced NHS spend and reduced workload in general practice. These were the Community Pharmacist Consultation Service (CPCS) and the Discharge Medicines Service. It was acknowledged that by demonstrating an ability to get these two services implemented, it would generate confidence to develop further services in the future.

To support this, we have produced [a briefing](#) aimed at PCNs.

“ If we cannot do the stuff that’s nationally been sorted, and has landed on a plate; the funding [for the CPCS] has already been sorted as part of the contract framework. If we can’t get general practice and PCNs to mobilise in partnership with their colleagues in community pharmacy. If we can’t do that, how are we going to innovate new stuff? ”

Viewpoint

Community pharmacy has a unique role to play in collaborating with its partners across an ICS to support the restoration of core services and the delivery of local priorities. It offers a combination of leadership of the medicines' safety and optimisation agenda, with clear benefits of improved patient safety and reduced NHS spend, and an ability to deliver a range of clinical services that reduce workload for primary care partners and increase patient access.

However, at a time of rapid change and exceptional challenge for the NHS and its partners, there is risk that the impact community pharmacy could deliver will be constrained by a number of barriers that are present in the current system.

The roundtable discussion highlighted these barriers and most importantly identified seven key tasks for national and local leaders to address to ensure that they are addressed in the emerging development of ICSs. Fundamental to all of them is a need to enable community pharmacy to play an active part in decision-making at all levels of the ICS and become integral to its clinical and professional leadership.

Appendix 1: Roundtable contributors

Andrew Lane, Chair, National Pharmacy Association

Michael Lennox, Local Integration Lead, National Pharmacy Association

Malcolm Harrison, Chief Executive, Company Chemists' Association

James Wood, Director of Contractor and LPC Support, Pharmaceutical Services Negotiating Committee

Helen Kilminster - National Vice President, Primary Care Pharmacy Association

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Graham Stretch, Executive Chair, Primary Care Pharmacy Association

Karen Livesey, Practice Business Manager, The Orchard Surgery

Laura Sherburn, Chief Executive, Primary Care Doncaster

Appendix 2: Key actions for PCN clinical directors, leads and community pharmacists

PCN clinical directors and leads

- Talk to your local community pharmacists about implementing the national NHS Community Pharmacist Consultation Service – this enhanced service enables general practice to refer patients directly to a community pharmacist for a minor illness consultation. The national specification is ready to go and once a local referral pathway has been agreed it can deliver an immediate benefit to patients and divert some of the workload away from GPs. More information can be found on the [PSNC website](#).
- Ensure that trusts in your patch are using the Discharge Medicines Service which is a service that all community pharmacists provide. This service has a demonstrated impact on patient safety and has significantly reduced hospital readmissions. More information can be found on the [PSNC website](#).
- Support community pharmacists in your area to navigate the ICS so that they can link into discussions about representation in the emerging governance arrangements and play their part in clinical and professional leadership.

Community pharmacists

- Find out what the key priorities and capacity constraints are in your PCN area – get together with your pharmacy colleagues in the area and discuss how your skills, and the services you could provide, would support the PCN to address them. If the Community Pharmacy Consultation Service isn't on your list it probably should be.
- Engage in a discussion with your PCN lead/clinical director – your local pharmaceutical committee will be able to facilitate these contacts. The earlier you do this the better as PCNs will be starting to look at how they represent primary care in the governance structure at place and system level.
- Remember that while PCNs have the general practice registered list at its core, primary care means you as well as GPs – and your colleagues in dentistry and optometry. The NHS Confederation is working hard to ensure that opportunities for clinical leadership are available to all primary care clinicians, with appropriate resources for backfill and development, so look out for leadership roles in your area. It may feel like you are stepping out of your comfort zone, but you will be warmly welcomed by your colleagues across primary care.

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