ROYAL
PHARMACEUTICAL
SOCIETY

Your views: building a strong, integrated care system across England

Royal Pharmaceutical Society response

1. What is your name?

Name: Heidi Wright

2. In what capacity are you responding?

In what capacity are you responding? Professional leadership body

3. Are you responding on behalf of an organisation?

Yes

If 'Yes', please provide the following details:

Organisation name:

Royal Pharmaceutical Society

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4. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Agree

If you have any specific comments or additional information to provide, please provide it in the text box below:

It is important that providers in health and care systems work in partnership and providing ICSs with a statutory footing will enable this. We support the need for greater collaboration between healthcare partners at an ICS level which will enable stronger partnerships to form and empower more inclusive local commissioning landscape. Such approaches will enable more tailored services and support for local populations and communities across the NHS to help improve patient care and safety.

However, there will need to be further discussions and greater clarity on the role of ICS as potential commissioners of primary care services to ensure that the current services, future planned services and the increasing role of pharmacy in the provision of services are maintained and maximised, to the benefit of patients, the public and the NHS.

Pharmacists have a role in strategic commissioning, clinical leadership, provision of specialist clinical expertise and provision of services. In order to achieve this the following will be required:

1. A defined **career pathway** for pharmacists working in all areas of practice. So not only, as currently, for pharmacists based in acute trusts but also for those based in community pharmacy, primary care, community services and in commissioning roles.

   To make this work then ICSs need to allow for pharmacist's roles to cross organisational boundaries (e.g. acute trust, general practices etc) and to be based on what the ICS has identified as the need for their populations "within places and "between places"

There needs to be adequate investment in the pharmacy profession to support professional development and advancement such as increasing the number of pharmacist independent prescribers.

ICS must ensure that there are training standards, curricula and assessments in place to support the development of healthcare professionals. With increasing demand for pharmacists working in advanced practice roles in multi-professional teams, professional development should not end at the point of registration. Pharmacists should be able to see a clear development pathway from registration through to consultant-level practice. This professional roadmap will support the recruitment of high-quality applicants into the profession and demonstrate to pharmacists how they can progress in their careers.

Pharmacists are playing an increasing role in primary care teams and will be central to supporting the NHS Long-Term Plan. Training standards, curricula and assessments must keep pace with rising public and professional expectations of pharmacists.

2. **Workforce**. The 'NHS workforce' must include pharmacy and this must encompass pharmacists working in all areas of practice such as general practice/primary care/CCG and community pharmacy teams.

   Pharmacists working for, and delivering services to, the NHS must be recognised as part of the NHS family and have equal access to national mental health and wellbeing services as well as resources provided by ICS resilience hubs

   Medicines are the most common intervention in the NHS and pharmacists, as experts in medicines and their use, need to effectively utilised by the NHS to ensure medicines optimisation and best value for m medicines for the NHS. Flexible models of service delivery need to be explored and encouraged, working across organisational and geographical boundaries, to ensure best patient care, for example, hospital outreach and specialist service provision in the community.

3. **Joined up services** will require collaboration between pharmacists not only across sectors (e.g. acute trust/primary care) but also within a sector (e.g. between community pharmacists). This is going to be a major change from the way pharmacists work and are funded for services.

   There will be a single pot of money to commission services as mentioned in the document (section 2.49). There is a clear role for pharmacy leaders in the ICS to commission services that allow independent contractors and NHS employed providers such as in mental health and acute trusts to have a level playing field.

4. **Reducing bureaucracy**. Increasingly more services are going to be commissioned by ICS's and consequently, community pharmacies in particular, will be faced with more complex systems for demonstrating they are meeting contractual requirements and also for claiming the funding. ICSs need to keep this as simple as possible. Ideally there should be the same systems used across ICSs so that, for example, a pharmacy chain operating in more than one ICS does not have to deal with different systems.

5. **Digital data**. Digital data can be used to shape services and the commissioning landscape to support pharmacy across the whole of the healthcare system.

   Pharmacists who are providing direct care to patients, and particularly those in community pharmacy, must have read and write access to patients' digital medical records. If this is not resolved at a national level, then ICSs need to ensure that pharmacy are offered digital access locally

   Pharmacists themselves have a role in helping with clinical informatics and shaping local population health approaches alongside quality improvement and research.

6. **Fragmentation of service provision**. Whilst it is the role of ICSs to identify the needs of local communities and commission services accordingly there are a number of problems with this approach:

a. Duplication of effort. In reality the health needs of populations do not vary greatly across much of England as local populations face similar issues such as increasingly older population (multmorbidity and frailty), deprivation, mental health problems etc.

b. There is a risk of post code provision and increased health inequality. Somebody should retain oversight (NHS England/Improvement) and be empowered to intervene where necessary. If all ICSs are commissioning the same thing then a standardised approach to commissioning and provision across England may be better in some cases.

c. Providers such as pharmacists may be requried by the commissioners to demonstrate competency in different ways for essentially the same service . This would affect service provision and provide an additional burden on healthcare professionals working in different ICS areas.

7. Large provider trusts have a lot of power. ICS have a role in encouraging and commissioning joint ways of working and need to ensure equity across all service providers. One single provider should not take over service provision.

5. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

Agree

If you have any specific comments or additional information to provide, please provide it in the text box below:

Whilst we agree that option 2 is a more sustainable option in the longer term, consideration and time needs to be given to make the necessary transitions, particularly in terms of CCGs and how their current duties will be taken on in the new structures.

If option 1 were to be taken forward, then both CCGs and ICS would be a commissioning point which would make the situation more complicated.

If option 2 were to be adopted, we have some concerns on the potential variances around the country that could result from this. There is likely to be more localised commissioning of advanced services which will lead to variances across the country. Assurances need to be given that the principle of patient choice which applies to NHS services, including genuine choice of which service provider to use, without any system incentive, is maintained.

6. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

Neutral

If you have any specific comments or additional information to provide, please provide it in the text box below:

We have some concerns that need to be addressed. These are:

- There should be a degree of local flexibility in ICS membership and governance
- However, experience of local NHS bodies has shown that pharmacy struggle to have a voice in an unstructured governance framework.
- Inclusive pharmacy representation that reflects the pharmacy workforce across primary and secondary care is critical and must be a part of this.

- Primary care providers struggle with representation too particularly those from pharmacy, dentistry and optometry.

We agree that membership will need to differ according to local needs but there needs to be a clear place for pharmacists at ICS level to ensure safe use of and the best value from medicines for patients and the NHS. This is supported by the NHS England and Improvement Integrating NHS Pharmacy and Medicines Optimisation (IPMO) programme[1] and we are encouraged to see the proposal for all ICS' to establish a pharmacy and medicines optimisation governance framework using the learning from the IPMO pilots and the COVID-19 tripartite leadership adopting a system pharmacy leadership model. The development of an ICS chief pharmacist role will ensure the work is undertaken across the system.

More use of Local Enhanced Services could leverage benefits of ICS to provide local services

7. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

Neutral

If you have any specific comments or additional information to provide, please provide it in the text box below:

Careful consideration will need to be given as to what services can be transferred and those which remain at a national level. Wider consultation will be required as some ICS will mature at quicker rates than others and will therefore be able to take on more commissioning duties at an earlier stage.

There is currently no clarity as to where pharmacy services sits in terms of the national contract. Currently CCGs co-commission GP services but not community pharmacy services. We are therefore unclear as to what proposal NHSE&I is making in relation to primary care commissioning, including whether it is proposed that ICS hold the Pharmaceutical List in the future. Clarity needs to be provided in relation to the community pharmacy contract and services.

The proposals mention the transfer of CCG staff to ICS but there is no reference to the transfer of NHSE/I staff currently working at different levels. There is a risk of loss of capacity, knowledge and skills of existing primary care commissioners within NHSE&I where roles are transferred.

[1] https://www.england.nhs.uk/primary-care/pharmacy/system-leadership/