ROYAL
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SOCIETY

RPS Recommendations and Case Studies for Integrated care Systems

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With the establishment of Integrated Care Systems (ICS), there are huge opportunities for integrated care across different organisations and settings. This includes more joined up working between hospital, primary care and community-based services, physical and mental health, and health and social care. Commissioners will need to make shared decisions with local service providers on how to use resources, design services and improve population health.

We strongly believe that pharmacists and their teams have a significant role to play within integrated care systems and more can be done to benefit patient care through strong strategic leadership across an ICS. Medicines are the most common intervention in primary and secondary healthcare and form a key component of all care pathways. The delivery of medicines priorities within an ICS requires close system working to benefit patients and communities. Multi-professional clinical and care leadership will enable excellent patient outcomes from medicines use and the pharmacy workforce.

We recommend those working at senior level within an ICS board focus on:

- Professional and Clinical Leadership and Engagement with the Pharmacy Profession
- Workforce
- Medicines Optimisation
- Commissioning
- Digital

As ICSs develop, we all need to adopt innovative practice, take learnings from the pandemic and share them across systems to deliver better care and outcomes for patients and the public.

1 Professional and Clinical Leadership and Engagement with the Pharmacy Profession

RPS RECOMMENDS THAT EACH ICS:

- Commit to meaningfully engage with the whole multidisciplinary team as part of any decision making processes across all primary and secondary care providers. All professions must be represented in decision making.
- Appoint a professional lead for pharmacy who must engage with all elements of the pharmacy profession. Having an ICS Pharmacy / System Lead will enable:
  - Support of the profession to ensure pharmacy is fully integrated into the wider system and the contribution that pharmacists and pharmacy teams can make are considered.
  - Engagement and collaboration with pharmacy stakeholders across the ICS to be a point of contact for all things pharmacy and medicines.
  - Development of a system wide vision for medicines optimisation, ensuring the safe use of, and best value for, medicines across systems.
  - Relevant data capture and analysis to make sure that population health is supported, and health inequalities are addressed.
  - Support and contribution to the development of workforce initiatives to ensure that best use is made of the pharmacy workforce.
- Develop a cross system transformation plan for all pharmacy clinical services across an ICS to ensure there is integration and joined up working for patient care. This will include engaging with other clinical professions and becoming integrated into clinical pathways.
- Ensure that there is a strong voice for primary care at system leadership and place-based levels. This must take place through critical leadership roles including pharmacy, clinical directors, teams across Primary Care Networks (PCNs) who build partnerships in neighbourhoods spanning pharmacy, general practice, community and mental health care, social care, dentistry, optometry and the voluntary sector.
- Ensure that pharmacy professionals have equal access to professional clinical leadership development opportunities and support for talent generation and future pharmacy leadership. This should apply to those who provide services to NHS patients and the public, as well as those directly employed by the NHS.

CASE STUDY 1:
POPULATION HEALTH-BASED APPROACH TO MEDICINES OPTIMISATION – NORTHUMBRIA

The Pharmacy team in Northumbria has developed a model which describes how medicines optimisation could be delivered across a large place-based system using a new population health-based approach across North Tyneside and Northumberland (2,500 square miles: population of 520,000). The model is ideally led by a consultant pharmacist for population health and includes a programme of quality improvement work relating to medicines use across the health and social care system. The whole-system pharmacy leadership post would be owned by all local key stakeholders, with an expectation to work with all relevant health and care organisations, patients and patient groups to:

- Better understand and define the problems with medicines use by engaging with other senior leaders.
- Better understand all available data sources and gaps in intelligence and insights.
- Agree key metrics and performance measures and timescales for a series of specific, integrated, timebound projects.
- Identify resources available to the system and sources of new funding.
- Co-develop solutions and pathways to test for improvement.
- Agree other deliverables and associated timelines.
- Use continuous quality improvement (e.g., PDSA) to implement, iterate and improve.

This approach would ensure that the best value and health outcomes from medicines are achieved by identifying and tackling issues that more traditional medicines optimisation activities may fail to deliver. Using a population health management approach, there is an opportunity to deliver key objectives, for example:

- Aligning the medicines optimisation priorities of the local Trust to that of the wider system, and vice versa; joining up the actions and efforts of otherwise disparate teams, working more effectively together, in the pursuit of better patient care.
- Investing in relationships and bringing key partners together (e.g., other Trusts, Primary Care Networks, Commissioning Support Organisation, Community Pharmacy, Public Health, Social Care); blurring organisational boundaries, developing shared priorities and delivering system wide working.
- Understanding and better linking key data sources for medicines to understand variation across the system.
- Using data and analytics to better inform decision making, directing medicines optimisation strategy, policy and actions and driving enhanced clinical care.
- Using national and local levers and contracts to drive a unified approach to medicines optimisation (e.g., structured medication reviews in PCNs and new community pharmacy contract).
- Tackling inequalities in the prescribing and deprescribing of medicines; identifying wider causes of inequality and working with new partners on collective strategies for improvement.

Liberating and/or better utilising system wide resources.

The Northumbria population health-based model and a draft business case for a consultant pharmacist in population health are available on request (england@rpharms.com)

2 Workforce

RPS RECOMMENDS THAT EACH ICS:

- Adopt a 'one workforce' approach and develops shared principles / ambitions / vision with all ICS partners and professional / clinical leaders including pharmacy. This will be supported by more cross sector working, particularly in a clinician's early years, but also the development of specialists who will work across a patient pathway in the future.
- Deliver the specific themes and actions set out in the NHS People Plan and include pharmacy in workforce planning for now and the future.
- Support the collation of robust workforce data to provide intelligence nationally and to help determine the workforce required to deliver population health within their ICS.
- Consider and implement new ways of using the pharmacy workforce, developing a whole profession collaborative approach to strategic workforce development across an ICS that recognises the full contribution that is possible from pharmacy. This could include:
  - Rotational roles across 'traditional working boundaries'
  - Utilisation of current independent prescribing workforce with clear modelling of how this workforce can be used across healthcare settings. In the future, all pharmacy graduates will be independent prescribers so ICS' will need to consider how best these skills can be utilised across systems.
  - Career progression across primary and secondary care, for example the development of consultant pharmacists for the frail elderly population working across the system.
  - New innovative clinical services across primary care to enhance collaboration and integration.
  - Utilising the pharmacy workforce, especially those working in the community setting, in supporting people to mitigate against health inequalities.

CASE STUDY 2:
INTEGRATED CLINICAL PHARMACY SERVICE
– WIRRAL, CHESHIRE AND MERSEYSIDE ICS

Wirral University Teaching Hospitals NHS Foundation Trust hosts an integrated clinical pharmacy service in which staff work across Primary Care Networks and within the hospital trust in Wirral Place, one of the integrated care partnerships (ICPs) in the system. The service grew out of an initial pilot, involving just four members of staff, to a team of 25 within just two years. Some of the staff rotate across the sectors while some are permanently working in split roles across both sectors.

The service was co-designed and developed with partners, resulting in an environment in which those delivering the service are naturally 'system thinkers', agnostic in terms of organisation, focusing instead on the patient. The ability to link with clinicians and other professionals across the local system; the use of IT systems in both sectors; as well as the relationships and trust which have been built, support the speedier resolution of any issues which might impact on patients and the local population.

As well as supporting members of general practice to resolve medicines issues encountered, the pharmacy team are also invaluable assets in the day to day running of practices. They have their own clinical caseload, run medicines optimisation clinics and support implementation of medicines safety strategies. Whilst working in hospital, they undertake clinical ward rounds across a range of specialties with a particular focus on admissions and frailty to support safe transfer of care. Working as one has many benefits, not least that team members are always cognisant of their actions and the impact they will have in a different part of the system.

3 Medicines Optimisation

RPS RECOMMENDS THAT EACH ICS:

- Develop an Integrated Pharmacy and Medicines Optimisation (IPMO) transformation plan ensuring access to medicines, and maximising patient outcomes, medicines sustainability and efficiency, while ensuring safe prescribing and best use of medicines.
- Establish a pharmacy and medicines optimisation governance framework using the learning from the IPMO pilots and the COVID-19 collaborations. This would include the establishment of an ICS Medicines Optimisation Committees (or equivalent) acting as single point of contact for medicines at ICS level and co-ordinating medicines optimisation across all care settings who would:
  - Establish sub-committees as required, such committees will need to be diverse and inclusive of the system.
  - Strive for equity across the system.
  - Devolve resource and decision-making.
  - Support research and spread innovation.
- Ensure that medicines optimisation, making the best use and value from medicines, is integrated into the development of all patient pathways. Medicines are a significant part of most patient pathways so must become integrated into them to support population health.
- Involve pharmacists in health inequalities workstreams as access to and use of medicines is a key area. Systems should consider the role of community pharmacy as a hub to support access to health improvement support and enable action on the wider determinants of health. More information on how pharmacy teams can help to address health inequalities can be found here
- Consider the recommendations of the National Overprescribing Review and how pharmacists, and other clinicians, can be best supported to put those recommendations into practice. Any changes to medicines should not be completed in isolation but consideration should be given to the entire supply chain from procurement through to patient impact.
- Adopt a net zero approach to the procurement and use of medicines. Pharmacists can undertake a number of actions to support this ambition in terms of the medicines agenda including:
  - Taking a person-centred approach to medicines use. Patients must be well-informed and actively involved in decisions about their care.
  - Providing medication reviews to identify potential medicines waste, improve compliance, deprescribe medicines not required, and change from high to low carbon products and low environmental impact alternatives where appropriate.
  - Educating the public about not stockpiling medicines, only ordering medications they need and disposing of unwanted medicines appropriately.
- Include the public and service users in service design across systems.

CASE STUDY 3:
INTEGRATED PHARMACY AND MEDICINES OPTIMISATION SYSTEM LEADERSHIP PROGRAMME - SOUTH EAST LONDON ICS

The South East London (SEL) ICS delivered sessions on expanding pharmacy leadership. The leadership training programme aimed to bring together a cohort of pharmacists from across the system to expand their leadership skills together. Pharmacists from a broad range of care-settings participated, meaning the cohort were able to meet and form relationships with pharmacists in different sectors to their own; useful in developing an understanding of the needs of pharmacists in other sectors and mobilising pharmacists around a Primary Care Network (PCN).

The approach was a bespoke training programme delivered by the Kings Fund and development of cross-sector network of ICS pharmacists.

The programme had impacts on the development of networking abilities, increased understanding of ICSs and the integration of pharmacy, as well as enhanced leadership skills. A network was enabled for course peers to liaise outside of the course to improve their local network and to better support patients, across the primary and secondary care divide.

By 2022, the expectation is for each PCN is to have up to six pharmacists to support their local neighbourhood, including one clinical pharmacy lead to work closely with a PCN Clinical Director. The Pharmacy Leadership programme was an opportunity to identify lead pharmacists and develop their skills to start building relationships to create a neighbourhood network of pharmacists and other health and care professionals involved in supporting people with their medicines.

The programme created the building blocks for a pharmacy network to deliver excellence in medicine use and patient outcomes in all care settings in SEL. The outcomes of the programme will help the system model pharmacy's leadership role in delivering the NHS Long-term plan.

CASE STUDY4:
INTEGRATED MENTAL HEALTH HUB – CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST

In Central and North West London NHS Foundation Trust, an 8B independent prescribing pharmacist worked within a consultant psychiatrist team covering one adult community mental health hub (17 GP practices) and a population of approximately 105,000 to help manage referrals and wait list for assessment and treatment as a result of the pandemic.

Referrals received from GPs, home treatment team and occasionally liaison psychiatry were triaged and allocated to members of the consultant psychiatrist team as appropriate. The prescribing pharmacist took on the responsibility of reviewing patients with complex medication needs which released capacity within the team, allowing the psychiatrists to focus on non-medication related reviews. Within 3 months, this model reduced the wait time for assessment and treatment from 12-16 weeks to 4-6 weeks from the point of referral.

The pharmacist supported the team one day a week; each session comprised of reviewing 3-4 patients. These included conducting a mental state examination, risk assessment, doing a thorough medication review and prescribing as appropriate followed by any necessary paperwork; writing outcome letters to GPs/referrers; follow-up and reviewing physical health tests such as bloods and ECGs. The clinic is in the early stages of implementation but since starting in July 2021, the pharmacist has released 21 hours of psychiatrist time over a 3-month period by reviewing 40 patients.

Interventions included initiating, switching or stopping medication; medicines optimisation; physical health monitoring; side effect management and referral to services such as social prescribing and psychology. On one occasion, the pharmacist was involved in organising an urgent admission following assessment of a patient who had significantly deteriorated in their mental state. Patients, staff and GPs are very satisfied with the service and the CMHT staff have reported feeling better supported as they have greater access to a specialist pharmacist for advice on medicines.

4 Commissioning

RPS RECOMMENDS THAT EACH ICS:

- Develop new ways of working and delivering care across systems that ensure the right professional is providing the right element of the patient pathway. There needs to be more collaborative commissioning opportunities with innovative approaches, engaging with the workforce and delivering population health. Services commissioned by ICSs will be designed and organised to reflect the expertise of those who provide the care, including pharmacists.
- Ensure that the services commissioned do not increase disparities in provision. ICS leads will need to support the implementation of nationally commissioned services across contractor professions as well as determine what additional services may be required locally. Funding must be adequate to support the delivery of high-quality services at both place and system levels.
- Consider how they can create better opportunities at both place and system level to enable collaborative working between services and teams and commissioning levers need to support this.
- Ensure delivery of key aims, coordinate pharmacy teams and resources across the system, drive the delivery of national strategic priorities and the NHS Long-Term Plan objectives relevant to the pharmacy professions at system and local levels, and to provide assurance of good system governance.
- Consider how they best use the pharmacy workforce to deliver population health and support people with long term conditions. This may involve the need to consider potential patient registration with a community pharmacy for devolved LTC management alongside shared care records and future IP practice.
- Engage with the pharmacy profession in the commissioning of public health services which will also help to address health inequalities. There is widespread recognition of the role pharmacists can play in improving health. More information on the role community pharmacists can play in public health can be found here.

CASE STUDY 5:
COMMUNITY PHARMACIST CONSULTATION SERVICE (CPCS) - BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE ICS

Pier Health Group based in Weston-Super-Mare were one of the initial pilot sites for CPCS implementation. The service has now become part of business as usual. The triage to a community pharmacy is part of a digital system and receptionists are trained to undertake the triage when on the phone to patients.

The whole system is administrator led and does not involve contact with GPs. Training of staff, both within the practice and at the pharmacy is key to making this work. The practice staff have full confidence in the referrals they are making.

Contact details are shared between the practice and the community pharmacies so any difficulties and issues can be discussed and dealt with quickly.

GP practices are struggling with capacity and the CPCS service can help with these workload issues. In this one practice alone around 110 CPCS referrals were made in one week and during the peak of Covid this went as high as 200 referrals in a week.

The practice has demonstrated that the service is safe and incorporates a feedback loop to ensure patients are seen or escalated appropriately.

One of the critical elements of the service is the use of appropriate language when referring patients. For example, receptionists say 'We've triaged your request and have decided that the most appropriate place for you to go is for a consultation with your pharmacist, which pharmacy would you like to go to?'

5 Digital

RPS RECOMMENDS THAT EACH ICS:

- Enable pharmacists in all care settings to be able to access, and input into, shared care records (ShCR) for individuals.
- Support transfers of care within and across care settings. ICS digital leads should develop digital pathways between NHS Trusts, community pharmacy and primary care adopting national interoperability standards such as the dictionary of medicines and devices (dm+d) and structured dose syntax.
- Allow for two-way communication and for people to be referred from one provider to another. Interoperability of systems is critical to enable data to be shared.
- Consider national guidelines to prevent duplication, particularly in applying digital standards and IG processes.
- Engage with pharmacists to support the interpretation of data to help deliver population health and support data driven care. Enable the data collected in pharmacies to be shared with the wider system to support data driven care.
- Work alongside their ICS digital transformation teams to ensure alignment with medication supply and support primary care access demands such as enabling digital prescription request access.
- Create single access dashboards to support pharmacy baselines and quality information data gathering to encompass all sectors which will support the triangulation of services.

CASE STUDY 6: ONE MEDICATION RECORD – DORSET ICS

Work is underway in Dorset ICS on a range of digital initiatives. One of these is the One Medication Record project as part of the wider Wessex Care Record.

NHS Pharmacy teams, IT teams, analysts, system provider partners and a range of stakeholders are working to develop a proof of concept at Dorset County Hospital and the aim is to use the shared care records to maintain a reconciled list of medications and feed this information back into other systems.

Within the Hampshire and Dorset systems, information relating to patient's medication is recorded in multiple locations, including but not limited to the GP systems, community pharmacy patient medication records, and NHS provider organisations, often using electronic prescribing and medicines management systems. There are also specialist medication records, for example that used for the substance misuse service in Dorset, chemotherapy prescribing and Integrated and Urgent Care Services.

With several different IT platforms holding information relating to patient's medication, this invariably leads to a fragmented information source with no one system having a complete record. This can lead to potential patient safety risks as patients move between different care settings within the system, for example, being admitted for an acute episode of care, or being managed by a specialist mental health service.

Working as an ICS to bring all the relevant pharmacists together, the lead pharmacist for the project anticipates that in future this system will reduce the many admission related prescribing errors when medicines are omitted, doses incorrect or medicines being re-prescribed that the patient no longer takes.

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