PM Healthcare
PROGRESS THROUGH PARTNERSHIP

Q&A panel questions

Neighbourhood Health - What it means for pharmacy across all NHS sectors

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Where does the panel think community pharmacy should play a primary role in the neighbourhood model; prevention, minor illness or long-term conditions?

All three. To an extent they are already doing prevention and minor illness as part of commissioned services like pharmacy first, smoking cessation etc. However managing LTC is one way that they can contribute to delivering the shift from hospital to community within neighbourhoods -NHS10 yr plan. With pharmacists graduating with prescribing qualifications there is the opportunity for them to manage single stable LTCs where medicines optimisation is a key component e.g asthma, hypertension. They are easily accessible in communities, especially to underserved populations who may not want to visit general practice as a first point of contact or for those where lifestyle interventions or adherence to medicines will significantly improve their long term conditions. Also staffing reflect the local communities they are located to provide culturally sensitive services and build trust

How can Community Pharmacy help shape Neighbourhood Health Teams if their voice is not heard?

It will be difficult to without a voice. ICBs should proactively support community pharmacy leaders to be engaged in NHTs. It will be helpful if community pharmacy voice can be heard through pharmacy voice as one, with more experienced ICB and hospital pharmacy leaders advocating for the whole profession including community pharmacy.

What are the panels thoughts about generalised roles in favour of specialist roles so that patients are not caught up in the referral pathway?

Need both specialists and generalists, not either or, to be easily accessible to patients along the pathway so that the appropriate pharmacist with the right skills sees the right patient based on their needs. Also part of specialists' role should be delivering through enabling the generalist to care for more patients through advice and guidance as well as training and education.

How do we ensure that neighbourhoods are about co-production that includes community pharmacy and changes the way we are involved and not just seen as a token rep?

Pharmacy must jump in upstream! NHT is happening at pace and new models are being tried. Those who don't get involved at this early stage will be left behind, including pharmacy. We can't wait passively to be invited, or influence from the outside. Some areas (we heard from Greater Manchester at the conference) are making progress, and successful methods, principles and learning should be shared to help adaptation and spread.

What are the focus areas the IN model will focus on? What process will be used to bring all these stakeholders together, align action and cut thro politics?

Locally we are focusing on Ageing well and frailty, multiple LTC 3+, Children/young people with complex needs. We've had wide consultations, however pharmacy is often forgotten because a) although medicines is a theme that cuts through , its not seen as big enough to warrant being a standalone issue to be tackled. b) aside from dispensing and some other statutory functions which have to be done by pharmacists, there's a feeling that other clinicians can manage/speak to medicines issues, until further down at which point pharmacy is contacted.

There's a large barrier to sharing clinical risk; partners may want to collaborate, but our setup compartmentalizes risk and responsibility

Agree, that this is true even within pharmacy across settings. Working together with shared goals, shared risks, common pathways etc within INTs will help build relationships/trust and begin to break some of the professional, organisational barriers across care settings and the system.

Many ICBs had care home pharmacists deleted from their structures. It was recognised during covid this role was important. How can ICBs influence?

I think through strategic commissioning- ensuring that care home providers are using data to identify and stratify residents so they can target the right medicines optimisation intervention to the appropriate residents, using the most appropriate trained/competent clinician particularly pharmacists. ICBs should ensure commissioned services have a clear strategy to optimise medicines for their care home residents, including deprescribing, and for managing patients with complex polypharmacy – all delivered by a pharmacy workforce fit for an ageing population.

This fits in with INT ageing well/frailty framework where proactive care should include identifying those needing SMR, preventing falls , advise and guidance on management of complex polypharmacy/deprescribing, optimising medicines in palliative and EoL care.

Is NHSE going to provide further guidance re integrators?

Currently, NHSE has not issued a comprehensive new wave of guidance on integrator roles, despite ongoing local variation and uncertainty reported in the literature. The expectation is that more practical guidance and a clearer professional framework will be needed for successful long-term integration and workforce development, especially as integration models and the role of clinical pharmacists in neighbourhood teams continue to evolve. With the announcement of the pilot neighbourhoods, we may see some of these models and guidance emerge.

Community pharmacy and adherence: what will be different this time?

Recent national ambitions for community pharmacy are more closely aligned to patient-centred care, digital connectivity, and embedding pharmacy in wider teams. What may be different now includes the use of better digital tools, integration of pharmacy teams into multidisciplinary settings, and the move towards more proactive, anticipatory care models, rather than reactive, transactional roles. Whether these lead to improved adherence will depend on robust collaboration with other providers and sustained support for role development. The role of the NHS app and AI may also influence our digital approach to adherence, and patient knowledge of their medicines, I am particularly keen to see how we develop non English models of medicines information.

Neighbourhood teams are dominated by GPs; how can non-advanced pharmacists contribute and sell their skills to GPs?

Non-advanced pharmacists can add value by focusing on the generalist approach which must be core to our role, medicines optimisation, supporting long-term condition management, and complementing the clinical skill mix. Demonstrating unique medication expertise, participating actively in MDTs, and sharing local successes and evidence of impact are all ways to build recognition and trust. Regular communication, involvement in audits, and sharing patient stories (e.g., improved adherence, reduced errors) are key strategies. The need for quantity and more importantly qualitative data can be supported by all pharmacists.

Where does shared care fit with the neighbourhood model?

Shared care is integral to the neighbourhood model: information flow and clinical responsibility for patients with complex needs should move flexibly between professionals in different settings (GPs, pharmacists in hospital and community, other health workers). Embedding shared care relies on clear protocols, digital interoperability, and regular cross-sector MDT meetings. The goal is to provide truly integrated, patient-centred management, especially for those with long-term or complex conditions, following the patient journey which does not just sit within the current traditional pathways. The use of the NHS app as a digital passport which can capture date from 'other' trusted verified services would help patients have greater control of their shared care, and allow clinical settings to manage the risk.

What's the update in digitalisation and joining up IT systems? This feels like a real blocker to progress.

Progress on digitalisation is widely described as slow and variable. Key barriers include lack of inter-operable records between primary care, community pharmacy, and hospitals; insufficient access to real-time data; and variability in investment across regions. Unified records and universal digital referrals remain policy ambitions but practical deployment is uneven. Stakeholders consistently identify IT as a critical, unresolved bottleneck to effective neighbourhood working. Nottingham city has been identified as a pilot neighbourhood, and have recently announced their digital approach to try and enable change - https://www.digitalhealth.net/2025/09/nottingham-rolls-out-digital-enabled-neighbourhood-health-service/

Hearing lots about opportunities for pharmacists; are the panel including pharmacy technicians in those answers?

There is growing recognition of pharmacy technicians' evolving roles in both primary and secondary care. Many national workforce and transformation strategies now explicitly include technicians, especially in medicines optimisation, supply functions, and patient-facing roles (sometimes leading clinics under pharmacist supervision). However, technicians often still feel overlooked in development planning, and a clear national credentialling framework is being advocated to enable their progression. I was recently at the Welsh RPS conference, where pharmacy trailblazers shared their stories, this included multiple examples of technician innovation. I believe the NHS sees the technician role as an important role, and is integral the pharmacy workforce. Great to see the level 4 and 5 qualifications being taken up and driving change, and also the work of APTUK and Liz Fidler ar NHS England with regards to leadership and scope of practice.

To what extent do you find current primary care contracting creates a barrier to neighbourhood integration and transformation? Any opportunities to change this?

Contracting structures remain a major barrier—funding flows and performance frameworks often reinforce siloed, practice-based activity rather than integrated, neighbourhood care. Opportunities for change include shifting to broader, blended funding models that incentivise collaboration, outcomes-based payment, and shared workforce development. Ongoing national reviews suggest enthusiasm for testing more flexible models but major policy change is yet to be implemented. We need shared contracting with both short and longer term outcomes linked to funding, with both national and local priorities.

Good point from Ankish. Not just PLT, but across many funding areas and grants. Which are open to GP practice but not pharmacy. Eg premises funding.

Discrepancies in access to funding (e.g., PLT, premises, grants) persist and are a frequent source of frustration. Many schemes and capital funds remain targeted at GPs or GP practices, with community pharmacy and multidisciplinary teams excluded from eligibility. Multiple reviews recommend moving towards parity of access, supporting innovation and infrastructure investment across all primary care settings. Consistency in eligibility criteria and support for team-based bids are widely advocated improvements. Hopefully with more shared funding models we will see more equity in this approach of protected learning, that also supports the development of local networks.

What services does Dr Nick feel could be shifted left out of GP practice in pharmacy first or public h to improve uptake, access and GP cap to focus on complex?

Currently Pharmacy First is for acute issues but I think the next big area is long term conditions, such as hypertension monitoring and asthma reviews. Many of these patients are young, fit, mobile and busy. Asthma in particular we know is often poorly controlled, ignored as not a big deal by patients but still kills 1500 people per year. We need to change the model and increase uptake of reviews. Another area is NHS health checks, though this quite often raises new issues which pharmacies may have less expertise in dealing with. Careful thought needed.

Is the shared care agreement working? I see more transfer of care.

Shared care is working well but is getting more complex. For example, GPs are frequently in shared care arrangements with private ADHD services which the GP is responsible for assuring are qualified and well set up to diagnose and monitor the patients. Shared care within the NHS is easier, though with shrinking secondary care capacity there has been a push to try and discharge patients despite the shared care agreement. Could shared care be looked at between secondary/GP and community pharmacy prescribers? Yes certainly.

What does the panel feel are the key shifts needed to ensure IPs in Community Pharmacy are at the heart of the MDTs to improve health outcomes for patients?

Neighbourhood health MDTs could and should involve pharmacy, but don't much presently. Better representation of comm pharmacy within LPCs will help - at the moment it is hard to set up an MDT with such a large and disparate group of pharmacies. The Single Patient Record will help.

How do we have a grown-up conversation about commissioning and contracting? The pharmacy contract is rigid in a way that the GP contract isn't (think regs).

Again, this is partly about strengthening the community pharmacy voice in formal settings regionally at ICB, Place, Provider Alliances and also in national fora. I think comm pharmacies need to be committed to this as a group of providers.

We know from a major study that most patients do not want to be seen by clinical pharmacist/nurse when doctors are unavailable. How can we address that?

This is a cultural shift which will take time. When patients have one good experience they will buy into it! Within PCNs this was a big shift in 2019 when we started employing pharmacists and it took a few months but our patients now love their PCN pharmacists! It is about how it is communicated, what the expectations are and making sure what is promised, is delivered.

How are commissioners going to support financial incentives to align? It's not just national funding but how local funding is focused on pathways NOT providers.

No-one knows this for sure, but locally in South West London my area, it will be led by the Provider Alliance. There will be considerable local power to shape this we are told.

Should pharmacy think more about meeting people where they are in their communities?

Yes! We do this a lot in my PCN area and have struggled a bit to have a meaningful liaison with community pharmacy. Neighbourhood health is all about doing this together, with GP, pharmacy, voluntary sector, residents groups, faith groups, social care, other NHS orgs etc etc. Co-design with our communities is what is hoped-for and expected.

How can you link in IP pathfinders in CP to set up MDTs with secondary care medical and specialist pharmacists without an integrated IT systems?

My current MDT set-up involves several providers who have different IT systems (community, GP, social care, hospital) and we just meet on teams and report in our part of the puzzle verbally. No reason why community pharmacy couldn't be part of this - we just haven't set this up yet in my area. One patient record will help, but we can't wait for that.

We launched one of the first neighbourhood's community mental health centres. Issues accessing data for outreach work. How does data access and ownership evolve?

Information governance (IG) is always a challenge but your ICB will have DPOs who can advise, as will the mental health trust. Statutory orgs will have different requirements to voluntary sector and others, but it has been done before and should not be a barrier.

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