

# Supporting joint working between community pharmacy and general practice

Learning from one year of Integration  
Lead roles in the East of England



July 2024

# Key messages

## What we did

The East of England region tested whether having part-time 'Integration Leads' based in community pharmacies would increase communication and joint working between pharmacies and Primary Care Networks.

The 6 Integrated Care Boards (ICBs) each recruited between 2 and 32 Integration Leads. Each Lead was funded to devote 20 days of time over the course of a year to work across a Primary Care Network (an average of 2 days per month). This included about 6 days worth of time for leadership training. To test the feasibility and impact of these roles:

- Leads kept records of their 2,562 activities and interactions
- community pharmacies, Primary Care Networks (PCNs), general practices, ICBs, Leads and other stakeholders took part in surveys at the start and end to describe any changes in perceived communication and collaboration. We analysed 672 surveys
- 204 Integration Leads, local stakeholders and team members who helped to train and support Leads took part in interviews

## What we achieved

Between June 2023 and June 2024:

- It was **feasible** to recruit, train and implement the roles with the resources available. 95% of the Leads recruited stayed in their roles.
- On average, community pharmacies said they knew more about PCNs and **felt more included** by the end of the testing period.
- On average, stakeholders reported an **increase in joint working** between community pharmacies and PCNs / general practices. Many stakeholders described how Integration Leads had facilitated this increased communication and collaboration. One ICB that tracked the number of referrals from general practices to community pharmacies found a 5% annual increase.
- We need to be careful about generalising because only a small proportion of pharmacies and practices gave feedback. The rollout of Pharmacy First in 2024 also had the potential to increase collaboration regardless of these roles. However **stakeholders from PCN areas without Integration Leads did not report as much change** in knowledge or joint working as the areas with Integration Leads. This suggests that some change may be attributable to the Lead roles.

## What we learnt

Leads trained practices to make referrals to pharmacies, made sure that pharmacy was a regular item on PCN meeting agendas and set up WhatsApp groups so stakeholders could discuss issues like medication stock shortages. However, Lead roles were not universally well regarded. Some PCNs and practices had not had much contact with their local Lead or had been dissatisfied with interactions. Stakeholders suggested that Lead roles should be given more time to embed, with strengthened processes such as:

- clear outcome **targets**, such as increasing referrals to pharmacies
- expanding to locality or **Integrated Neighbourhood Team areas**
- monitoring the **consistency** of what Leads do so all areas benefit
- including further opportunities for development and **peer support**
- encouraging ICBs and PCNs to look at sustainable ways to **fund** roles

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## Acknowledgements

6 Integrated Care Boards and their partners tested Community Pharmacy Integration Lead roles, compiled information and reflected on lessons learnt. The former Health Education England funded training and Leads' time. An independent team from The Evidence Centre compiled the data. Images are sourced from NHS England, ICBs and pexels.com.

The teams that managed this pilot would like to thank everyone who acted as an Integration Lead, those who supported and trained them, organisations that interacted with the Leads and everyone who provided feedback about their experiences.



# What we did



## Setting the scene

### Background

Community pharmacy is a key part of primary care. The [NHS Community Pharmacy Contractual Framework](#) 2019-2024 describes how pharmacy services are expected to support the delivery of the [NHS Long-Term Plan](#) and be partners in [Primary Care Networks](#) to improve population health.

It can be challenging to put this vision into practice. East of England's Primary Care Public Health Transformation Programme Board reviewed local enablers and barriers to integrated working between community pharmacies and Primary Care Networks (PCNs). The Board concluded that:

- there was a lack of understanding within PCNs and general practices about what community pharmacy can offer
- PCNs and community pharmacies do not have enough time and capacity to build relationships and have constructive dialogue
- it is difficult for community pharmacy teams to take part in PCN discussions due to legal and contractual requirements that mean pharmacists cannot leave their workplace without backfill
- funding models may drive competition between providers

As part of a wider set of actions to support integrated working, the East of England region tested having liaison roles to build relationships between pharmacies and their local PCN and general practices between June 2023 and June 2024. This approach was championed by local pharmacy representative committees.

### Ambitions

The main things that the East of England region wanted to achieve over a 1-year period were:

1. to **learn** whether it is valuable and worth sustaining liaison roles based in community pharmacy
2. for community pharmacies to know more about their local PCN and **feel more involved** in and valued by the PCN
3. for PCNs and general practices to **know more** about what community pharmacy can offer
4. more **collaborative working** between community pharmacies and PCNs

The region hoped that greater collaboration would lead to improved processes, services and patient outcomes in the longer term, but commissioners were realistic that it would take more than 1 year to be able to measure changes like this.

The focus in the first year was to understand whether the model of having part-time liaison roles was feasible and whether there were any short-term impacts on knowledge, engagement and joint working.

## Approach

The approach to achieve these ambitions was to recruit people already working in community pharmacies to take on the role of 'PCN Community Pharmacy Integration Leads' (hereafter referred to as Integration Leads). Most Leads were pharmacists. The Leads were funded for a maximum of 20 days across the year, which equates to around 3 hours a week.

Each of the 6 Integrated Care Boards (ICBs) in the East of England oversaw implementing the model in their area. Individual ICBs used slightly different processes for recruitment, induction, training, management and support.

There are about 148 PCNs and 1,216 community pharmacies across the East of England. The pilot included 50 of these PCNs (34%). One ICB recruited an Integration Lead for every PCN. Other ICBs tried the role with a small number of PCNs before considering wider expansion.

- Bedfordshire, Luton and Milton Keynes recruited 3 Leads
- Cambridgeshire and Peterborough recruited 2 Leads
- Hertfordshire and West Essex ICB recruited 31-32 Leads, one for every PCN area
- Mid and South Essex recruited 5-6 Leads
- Norfolk and Waveney recruited 3 Leads
- Suffolk and North East Essex recruited 5-6 Leads

Some Leads covered multiple PCN area and the number of Leads in post sometimes changed over time.

Integration Leads began in June, July or September 2023, depending on the ICB. All Leads took part in an induction plus formal leadership training sessions, which varied depending on the area. The former Health Education England provided funding towards salary costs and training. ICBs, training hubs and local pharmacy committees contributed management and support time.

The Community Pharmacy Contractual Framework had provided funding for similar liaison roles in the [past](#), with a focus on flu immunisations. The current pilot was different because Integration Leads were not limited to promoting a specific service and the focus was on wider integration.

Box 1 describes the broad activities the Integration Lead roles were expected to undertake.

### Box 1: Expected activities of Integration Leads

- Take part in **leadership training** as a stepping stone to take on 'clinical lead' roles similar to other primary care professions
- **Liaise** with PCN-based Pharmacist, Clinical Director or similar to learn about PCN initiatives and priorities and communicate these to local pharmacies (with at least 2 meetings expected with PCNs)
- Embed the **community pharmacy voice** within PCN meetings and structures
- Link with the local pharmacy representative committee and Integrated Care Board about potential pathway changes and **service development** opportunities (e.g. Pharmacy First)
- Build **communication with community pharmacies** across the PCN footprint and neighbouring pharmacies if relevant (including facilitating at least one group meeting with all community pharmacists and setting up communication mechanisms to engage with pharmacies on a regular basis)
- Work with the PCN to develop rotational undergraduate and foundation pharmacy student **placements**
- Keep **records** of activities and take part in evaluation surveys and interviews

Note: Information is based on the funding proposal and Lead role descriptions / memorandum of understanding.

# Understanding impacts

The East of England region worked with an independent evaluation team to review:

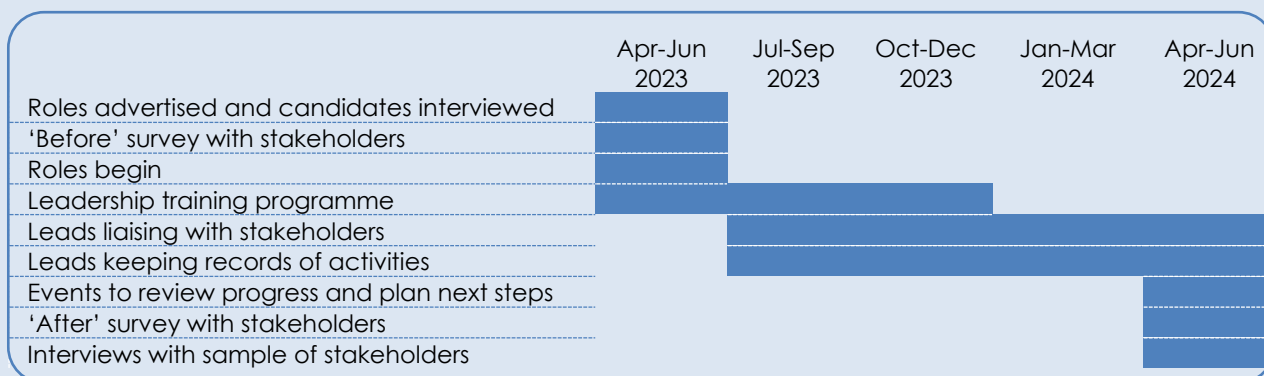
- What impact did Integration Leads have in the first year for pharmacies, PCNs and general practices?
- What helped and hindered implementation of the model and are there any areas for development?



Information for the review was collected by:

- **surveying** representatives from community pharmacies, PCNs, practices and other stakeholders about how much they know about and are working with potential partners in June 2023 and again in June 2024
- asking Integration Leads to complete a standardised template to **log activities** and reflections each month
- **surveying Integration Leads** to self-assess their knowledge and confidence at the beginning and end of the first year
- video-conference, telephone and in-person **conversations** with Integration Leads and representatives from ICBs, PCNs, practices, local representative groups, training hubs, training providers and others to reflect on lessons learned towards the end of the testing period
- monitoring **official data about referrals** to community pharmacy from general practices (provided by one ICB)
- surveying and telephoning community pharmacies, general practices and PCN representatives in East of England **areas that did not have Integration Leads** at the start and end of the testing period. The purpose was to be able to compare perceptions of knowledge, involvement and joint working amongst areas that did and that did not have Integration Leads

Figure 1: Broad timeline of the testing period



The progress review is based on records about 2,563 activities, 672 survey forms and 204 interviews (Table 1).

The following section describes what Integration Leads did and whether there were any changes in stakeholders' reported knowledge, confidence and perceived collaboration. There were some differences between how ICBs implemented the roles, but overall the short-term impacts were similar between areas. This report describes impacts as a whole, rather than dividing by geographic areas. Most ICBs only had a small number of Leads so the numbers are too small to make generalisable comparisons. We also wanted to maintain anonymity. However, the final section describes lessons learned, which includes stakeholder opinions about things each ICB area did well and factors that helped and hindered progress.

The report reviews the overall approach of having Integration Lead roles. It is not a judgement about the work of individual people who took on these roles. Any comments about impacts or areas for development are about the model of having Lead roles, not about individuals.

**Table 1: Data for the review**

	Bedfordshire, Luton and Milton Keynes	Cambridgeshire and Peterborough	Hertfordshire and West Essex	Mid and South Essex	Norfolk and Waveney	Suffolk and North East Essex	<b>Total</b>
Activities logged by Leads	65	175	1895	61	136	233	<b>2562</b>
Leads surveyed at start	1	1	18	0	3	2	<b>25</b>
Leads surveyed at end	1	2	14	5	3	4	<b>29</b>
Pharmacies surveyed at start	40	26	41	0	16	20	<b>143</b>
Pharmacies surveyed at end	21	22	69	11	31	16	<b>170</b>
Practices, PCNs, ICB and other stakeholders surveyed at start	15	11	40	0	30	32	<b>128</b>
Practices, PCNs, ICB and other stakeholders surveyed at end	10	17	99	14	22	15	<b>177</b>
Interviews with Leads, pharmacies, practices and others towards the end	30	30	54	30	30	30	<b>204</b>

Note: Numbers include people surveyed and interviewed from PCN areas with and without Integration Leads.

# What we achieved



## Building leaders

### Recruitment and retainment

Each of the 6 ICBs used its own process to recruit people to Integration Lead roles. This generally included:

- advertising in existing newsletters
- sending a bulk email to all community pharmacies describing the role and job description
- mentioning the opportunity during existing meetings
- in some cases, approaching potential candidates directly and/or working with the local pharmacy committee on recruitment
- in some cases, offering an information session for people to ask questions

The ICBs interviewed candidates, sometimes alongside partners. Hertfordshire and West Essex recruited a Lead for every PCN area. In most cases there were not multiple applicants competing for a role in the same PCN. Where more than one person applied, they were allocated a neighbouring area.

Other ICBs either selected specific PCNs that they wanted to recruit for based on particular population needs, or decided which PCNs to include based on where candidates who applied for Integrated Lead roles were located.

The ICBs recruited 50 Leads. Almost all of these were pharmacists working in community pharmacies. This was a pre-requisite for some areas. Other areas had wider criteria so a small number of people were pharmacy technicians and a small number worked as pharmacists within general practices.

About 95% of Leads stayed in their posts for the year. 3 Leads withdrew, citing workload issues. One Lead was replaced. In another area a Lead took responsibility for two PCNs. In the third area, there was no replacement.

### Training

The East of England region wanted to help the Integration Leads develop further expertise in communicating with and influencing a wide range of people, managing change and identifying and addressing barriers. Some areas had a vision of the Leads becoming 'clinical leads', like posts held by other professions in ICBs.

For this reason, the ICBs decided to allocate a substantial portion of Leads' funded time to training.

Leads took part in leadership training run by external trainers. Training equated to about 6 full days of time spread over about 6 months (which came out of the 20-days of time allocated to Leads across the year). The training content and approach varied slightly by area. Hertfordshire and West Essex used one training provider, Mid and South Essex used another, and the rest of the areas combined to use another provider. The trainers used a mix of online and face-to-face sessions. Some included pre-recorded e-modules and one-to-one coaching. Content focused on communication, influencing and leadership skills. In addition to 'lectures', the training programmes provided opportunities for Leads to describe their progress, gain peer support and help each other with any challenges.

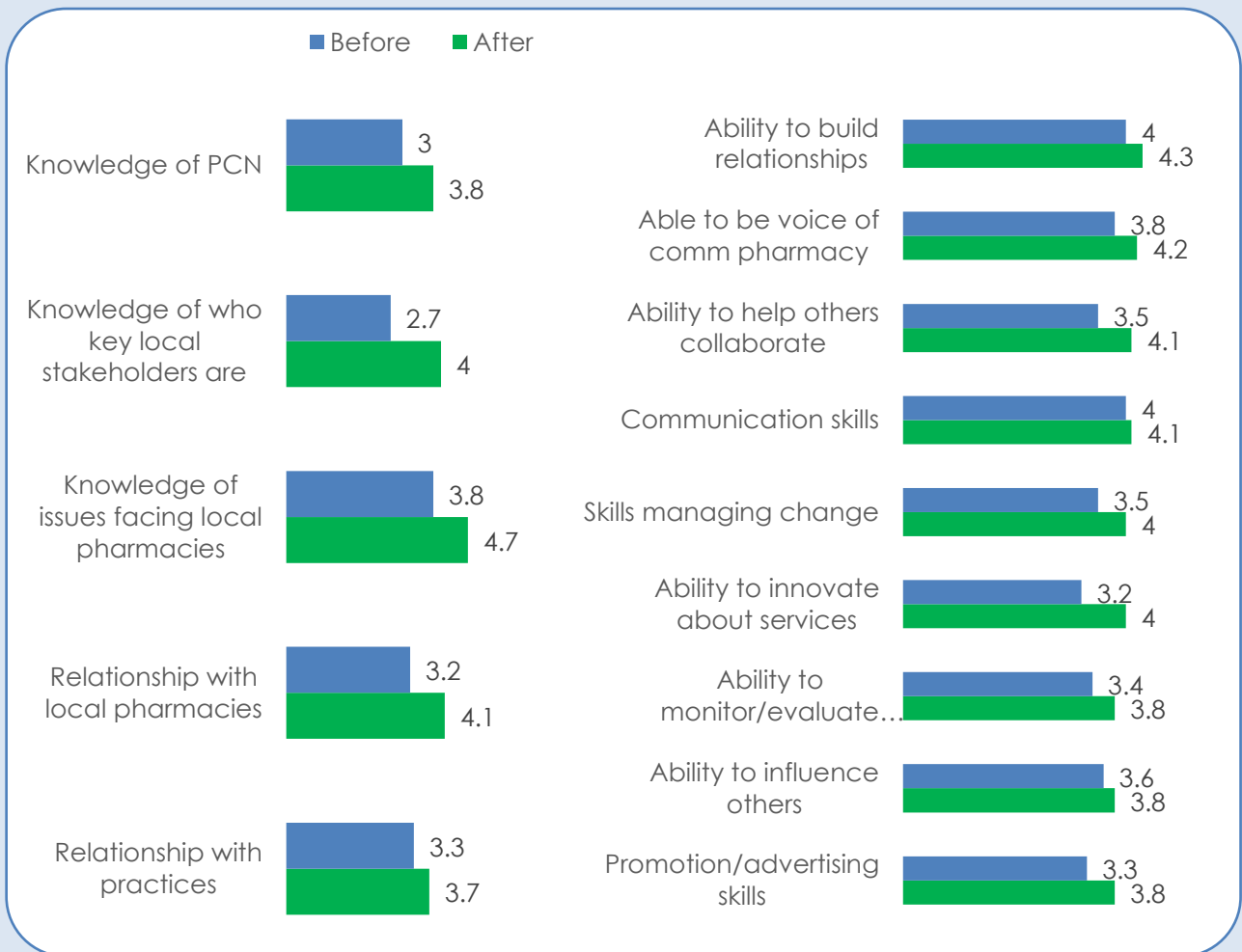
Most areas also offered a local induction session to provide information about the Integrated Care System and how primary care was structured, funded and organised. Some areas introduced Leads to key stakeholders such as local representative committees. Some ICBs also had progress update meetings every month or quarter with Integration Leads or tasked the training providers to do this on their behalf.

Leads completed online surveys at the beginning and end of the pilot period. Figure 2 shows that, on average, Leads rated their knowledge, confidence and skills more highly in 2024 compared to 2023. Leads felt they knew more about the PCN, who local stakeholders were and the issues facing local community pharmacies. They also rated their relationships with community pharmacies and local general practices more highly than when they started the role.

The exact numerical ratings are less important than the overall trend – which was that Leads consistently rated their knowledge and confidence higher in 2024 than in 2023. Although the sample size is small, the overall change was statistically significant compared to what we would expect to happen by chance.

There are some caveats with this information. Firstly, only half to two thirds of Leads provided feedback so the results may not be generalisable to everyone. Secondly, people’s assessments of their own knowledge and skills may not be ‘accurate’. However, one of the goals was to increase people’s confidence in their own abilities, so it is positive that Leads rated themselves more highly on every measure.

**Figure 2: Integration Leads’ self-reported knowledge and confidence (on 5-point scale)**



Note: 25 Leads answered in June 2023 before starting their roles. 29 Leads answered in June 2024, at the end of the first year. Numbers are the average score on a scale from 1 to 5.

# Increasing pharmacy engagement

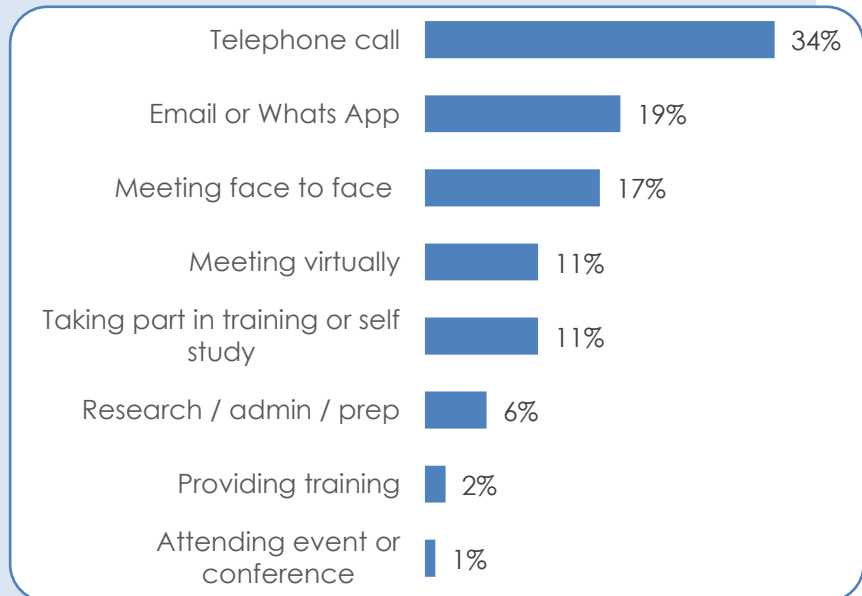
## Activities done by Leads

Integration Leads logged 2,562 activities during the year. The total number would be higher because about one quarter of Leads did not provide records. Some Leads provided records but did not log all their activities such as training, planning or administration.

The Leads described activities such as telephone calls, emails, meetings and taking part in training (Figure 3). In the first 6 months, around half of Leads' time was spent on training. In the final 6 months, regular training sessions were coming to an end for most Leads and they spent more time liaising with community pharmacies, PCNs and general practices (see Box 2 for examples).

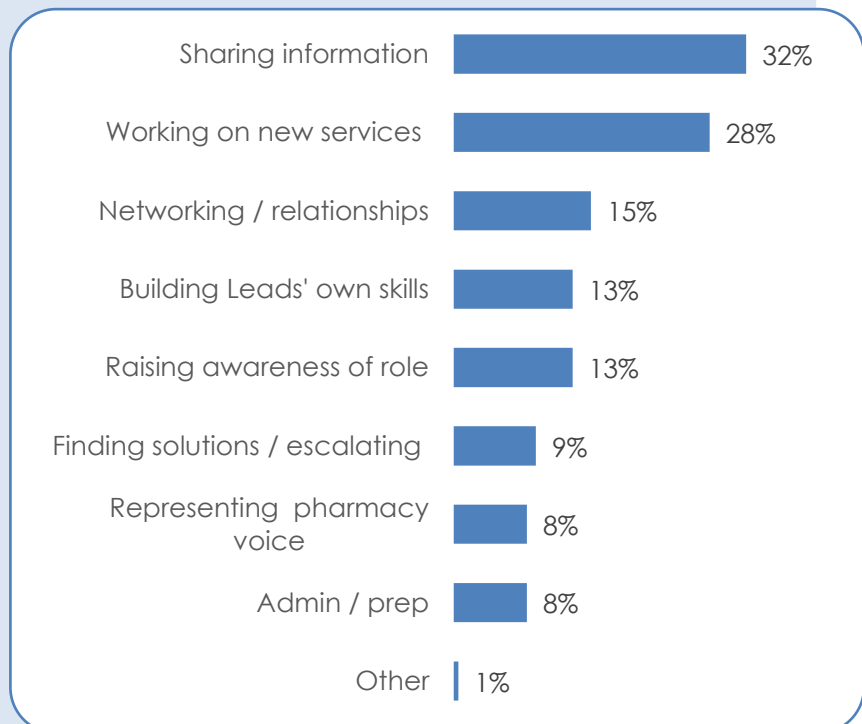
Many of the activities revolved around sharing information with community pharmacies or practices (Figure 4). After Pharmacy First was launched in 2024, a greater number of activities focused on implementing these services. Pharmacy First is a national programme enabling community pharmacists to treat seven common health conditions: earache, infected insect bites, a bacterial skin infection called impetigo, sinusitis, sore throat, shingles and uncomplicated urinary tract infections in women. This includes supplying prescription-only medicines to patients on the NHS, without needing to visit a GP. Patients can get treatment by walking into the pharmacy or contacting them virtually. GP receptionists, NHS 111 and emergency care providers can also make referrals. This document is not an evaluation of what helps and hinders implementing Pharmacy First.

Figure 3: Types of activities undertaken by Leads



Note: % based on 2,562 activities reported by Leads.

Figure 4: Main purpose of activities undertaken by Leads



Note: % based on 2,562 activities reported by Leads. Percentages add to more than 100% because activities could have more than one main purpose.

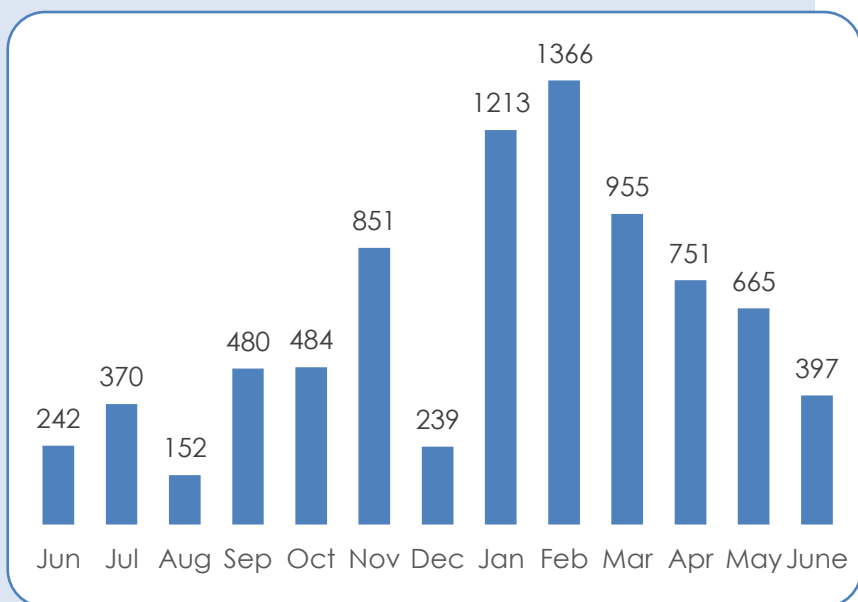
Over the course of the year, Leads documented having over 8,000 stakeholder contacts (not including with other Leads). This counts people that Leads were in contact with multiple times more than once. The purpose of providing these figures is simply to show the scale and range of the work Leads did. In the first 3 to 6 months, most Leads were primarily contacting community pharmacy representatives. Towards the second half of the year, this shifted to include more contact with PCNs and individual practices.

On average, Integration Leads reported undertaking about 5 activities each per month, or about 50 activities per year. There was wide variation, with some Leads reporting many more activities each month and some reporting very few.

On average Integration Leads reported that they were in contact with about 17 people each month. Some of these were people they actively engaged with. Others were people that attended the same conference or event that a Lead was listening at. Again there was wide variation, with some Leads reporting being in touch with hundreds of people over the year and some having less than 30 contacts. The quantity of contacts is not necessarily an indicator of the quality of work done or the impact.

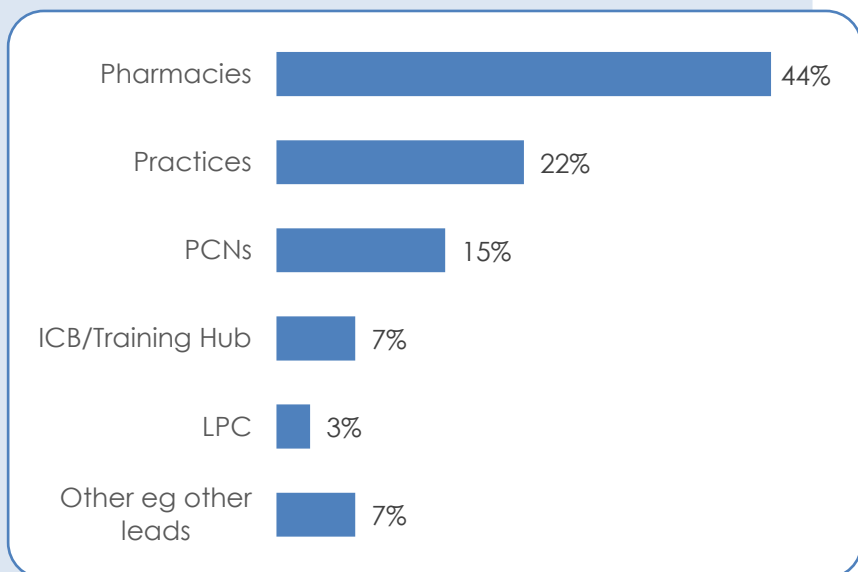
Although the pilot period was 1 year, it took 6 to 9 months before the Leads were spending most of their time on liaison activities and interacting with a wide range of stakeholders. This is not a critique, but rather an observation that there was a relatively short period in which the roles were implemented fully.

**Figure 5: Number of stakeholder Leads reported being in contact with per month**



Note: Leads were asked to work an average of 2 days per month except for August and December, which were deemed breaks (though some Leads worked these months).

**Figure 6: Types of stakeholders Leads engaged with**



Note: % based on 2,562 activities reported. Percentages add to more than 100% because Leads could engage with more than one type of stakeholder during each activity.

## Box 2: Examples of activities undertaken by Leads



"I **set up WhatsApp groups** so practices and pharmacies could all be in touch informally. I **contacted all pharmacists** to see how they were getting on with training to offer Pharmacy First services. I put together and **provided practices with a list of every service available** from each of the pharmacies. I **visited practices** to answer questions about Pharmacy First and **train reception teams** about how to make referrals. I met with the **PCN clinical director** to discuss what was getting in the way and came up with an action plan to move things forward. All the pharmacies in my area are now offering multiple Pharmacy First services. They are all getting signposting from practices, and more practices are starting to provide formal referrals. I am now visiting every practice to discuss how things are going and sort out any issues." (Integration Lead)

"[Integration Lead] helped pharmacies and the GP surgery **share flu vaccines** that were going to expire. That prevented waste and increased patient access to the shots. We were able to get vaccines out to housebound people or those who could not easily get to the surgery. We used up all the expiring vaccines by working together to get them to as many people as possible. This helped to stop hundreds of pounds worth of vaccines being thrown away." (GP)

"[Integration Lead] has arranged for pharmacy to be a standing item on the Integrated Neighbourhood Team locality **meeting agenda**. She attends the locality and **PCN meetings** to provide a pharmacy perspective and highlights things we need to know." (PCN representative)

"[Integration Lead] set up a **WhatsApp group** to share info with us pharmacies. Now the pharmacies use this to contact each other ourselves. Every few months, [Lead] organises a **get together** for pharmacists to meet informally. That's helped us get to know each other so we feel able to pick up the phone or text if needed at work. It took a few months to build trust, but now it feels like we are a little community of pharmacies. Before we didn't know each other and didn't work together so [the Lead] has helped to **build this network**." (Community pharmacist)

"A practice had concerns about a pharmacy. They said patients were not getting their medication quickly enough. The practice was also concerned about referring patients there if they were going to be turned away. They had contacted the pharmacy but had no response. I **liaised** between the two to start a communication channel in the interests of local patients. I also did this when one pharmacy had concerns about another pharmacy. I was not a mediator. I was just there to get people talking to one another." (Integration Lead)

"We worked with [Integration Lead] and the PCN and ICB to improve electronic prescribing. We've moved from a paper system to fully **digital**. [The Lead] **put us in contact with the right people** at the ICB to help. Things are quicker and smoother for the practice and pharmacies. This wouldn't have happened as quickly if [Lead] wasn't there." (Practice manager)

"A GP told me there was no point referring people to a certain pharmacy because sometimes the patient was just referred back. I talked to him several times to **increase awareness** about the reasons why that would happen. I explained the eligibility criteria and how pharmacists are clinical experts making decisions about what is in their scope of practice. I described cases where pharmacies had been able to reduce wasted GP appointments to show that referrals can work well. I asked the GP let me know about any future returned referrals that he was concerned about. I contacted the pharmacies and asked them to tell me about referrals that were outside our scope of treatment and which surgeries these were from. I then **followed up with the surgery** every time there was a returned referral to talk about the criteria and work with them to get the correct patients referred. It is early days, but I am getting less reports of inappropriate referrals or bounce backs. Instead of practices getting frustrated and just not making referrals, now we have a process to make sure the referrals are right and address if anything goes wrong." (Integration Lead)

## Impact on pharmacy engagement

The number and types of activities Leads did is background information. More important is whether those activities had the desired impacts. One of the desired impacts was for community pharmacies to know more about and feel more involved in their PCN. We surveyed community pharmacies across the East of England at the start and again at the end of the pilot. In areas with an Integration Lead, there was an increase in the proportion of community pharmacies that said they were informed about PCN activities and felt involved and valued by their PCN. Community pharmacies in areas that did not have an Integration Lead started from the same baseline, but there was no increase over the year (Figure 7). The difference between areas with and without a Lead was statistically significant, meaning it probably is a real change.

15% of pharmacies in the East of England chose to take part in the survey (which was advertised by local representative committees, Integrated Care Boards, PCNs and Integration Leads). Response rates for online surveys are often around 10%, so this was an expected level of response, but it means we cannot assume the feedback represents all pharmacies.

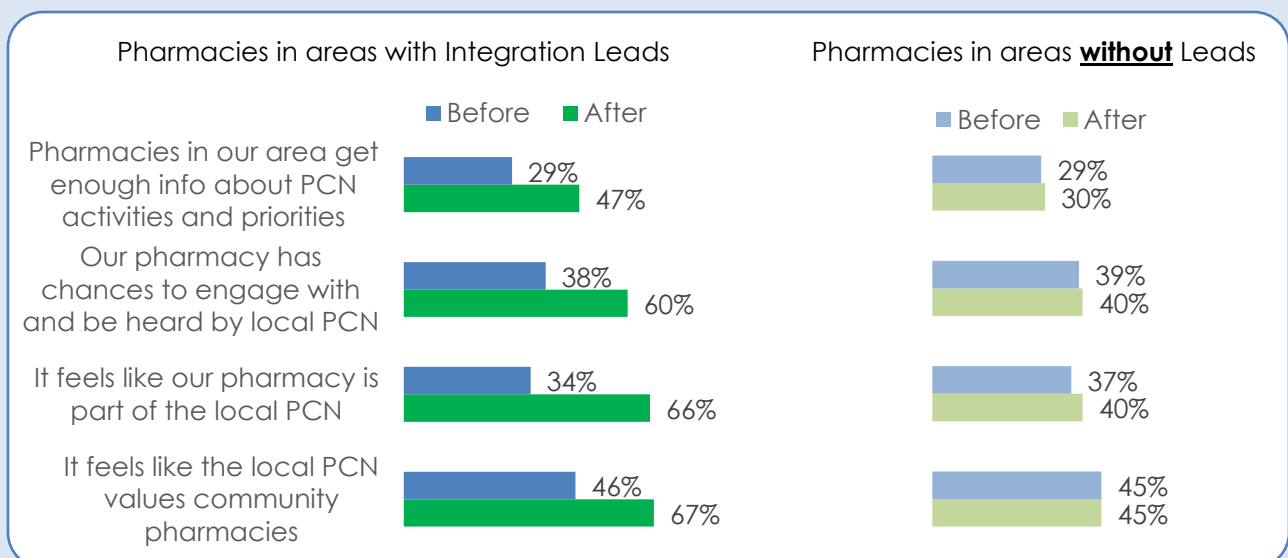
In interviews, community pharmacies in areas that had Integration Leads often mentioned the Leads by name, and talked about how the Leads shared information from PCN meetings or acted as a conduit or liaison person. This suggests that Leads contributed to the changes found in the survey.

"I've never had much contact with other pharmacies or practices. In the last 6 months, [Integration Lead] has been in touch regularly to let us know what's going on. She goes to meetings on behalf of us pharmacies and reports back. She asks what we want discussed with practices. She sort of campaigns to let people know what's realistic for us and tells them our challenges. It feels like there's more two-way conversation and she's the channel." (Community pharmacist)

"There are 6 pharmacies in our area. Our PCN couldn't liaise with all of them every time we wanted to do something. So having a Lead to coordinate what pharmacies think and feed that in to us has been good. It makes it feasible. I feel like we're listening and valuing pharmacies more." (PCN representative)

Whether they had an Integration Lead or not, pharmacies mentioned scope for more involvement and sharing.

**Figure 7: Extent to which community pharmacies feel informed, engaged and valued**



Note: Percentages are the proportion who agreed with a statement. In areas that had an Integration Lead, 76 pharmacies completed surveys at the start and 58 at the end of the testing period. In areas that did not have an Integration Lead, percentages are based on 67 pharmacies at the start and 112 at the end.

# Increasing knowledge of pharmacy

Another desired impact was for PCNs and general practices to know more about what community pharmacy can offer and the challenges facing community pharmacy. The trends here were similarly positive.

Representatives from practices, PCNs and community pharmacies rated how much their local PCN knew about community pharmacy activities and issues. Areas with and without Integration Leads had similar ratings at the start of the pilot. By the end of the pilot, the average rating was higher in areas that had an Integration Lead. In other words, areas with an Integration Lead thought that PCNs were more informed about what community pharmacy could offer by the end of the pilot (Figure 8). There were similar trends in perceptions of how much general practices knew about what community pharmacy can offer.

The difference between areas with and without a Lead was statistically significant, meaning we would not expect it to happen by chance.

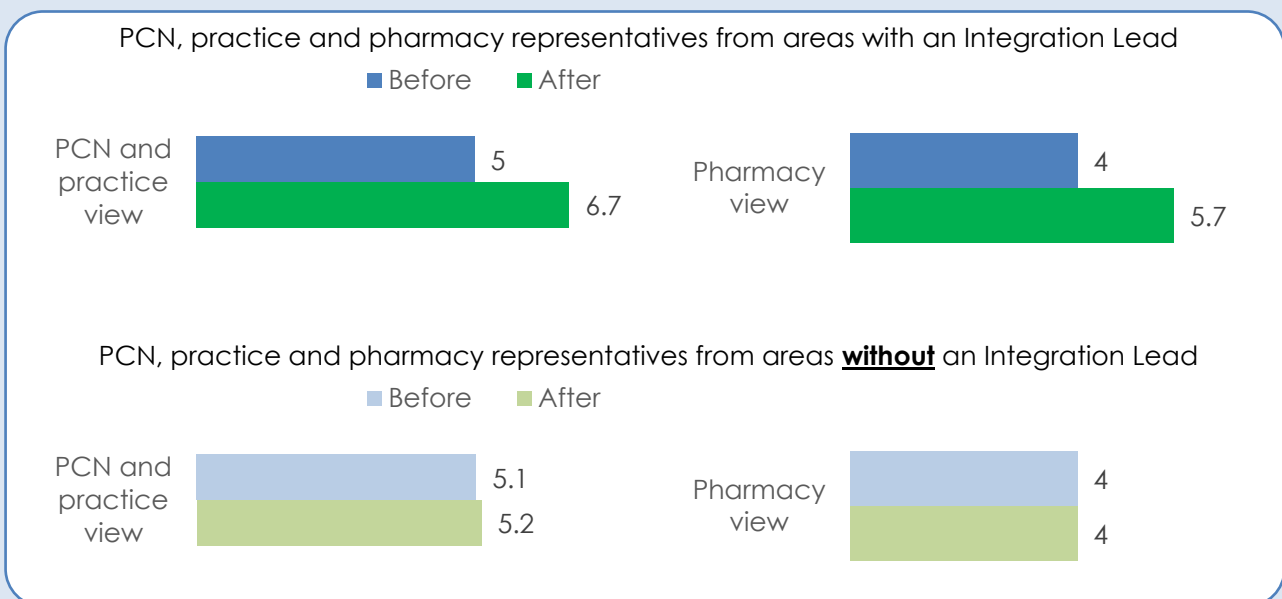
Once again, we need to be cautious about generalising these findings due to the response rate. Around one quarter of PCNs and practices took part in the survey.

The survey is backed up by interviews. Representatives from PCNs and practices with an Integration Lead often spoke positively about the role that Leads had played in increasing their understanding of the potential of community pharmacy.

“This year I’ve begun to learn more about how our local pharmacies work and why. I see that they can have a more direct role in helping my patients, not just dispensing. Having [Lead] visit to train our reception team about Pharmacy First referrals was a big part of that. We have an ongoing relationship sorting out issues and dealing with stock shortages. I feel more confident directing patients to pharmacies.” (GP)

“In the last few months, we’ve got a better handle on what community pharmacy can do and how we can work alongside them better as a PCN. [Lead] has really helped with that.” (PCN representative)

**Figure 8: Average rating of how much PCNs know about pharmacy activities and issues (out of 10)**



Note: The survey asked ‘how much does the local PCN know about community pharmacy activities and issues?’. People rated from 1 to 10, where 10 was highest. In areas with an Integration Lead, 76 pharmacies answered at the start and 58 at the end. 78 practice and PCN representatives answered at start and 110 at end. In areas that did not have an Integration Lead, 67 pharmacies answered at the start and 112 at the end. 50 practice and PCN representatives answered at the start and 67 at the end.

# Supporting joint working

## Perceived collaboration

The other short-term impact that we monitored was perceptions of working collaboratively. The trends were positive here too.

In interviews and the survey, many community pharmacy representatives said there was more collaboration with practices compared to a year ago. They also said there was more networking and joint working between pharmacies themselves.

Many representatives from PCNs and practices also said they had collaborated more with community pharmacies in the past year (Figures 9 and 10).

“We’re in contact more with other pharmacies and the local practice. We have a WhatsApp group where we sort out stock shortages. The practice is referring patients for Pharmacy First services. A GP even called the other day to ask advice about what formulations a medicine came in. I’ve never had that before.” (Community pharmacist)

“We have a pharmacist at our monthly PCN meetings now so pharmacy is on the agenda. We work together at meetings to figure out issues and plan what to focus on. It’s very practical.” (PCN representative)

“Sharing a list of excess stock with other pharmacies and encouraging a culture of information sharing was an initiative that promoted resource optimisation and collaboration. This task highlighted the benefits of inter-pharmacy cooperation in managing inventory more efficiently, reducing waste and ensuring that medications are available where they are most needed. By fostering an environment of openness and mutual support, we were able to enhance the resilience and responsiveness of our pharmacy network. This experience demonstrated the value of shared responsibility in achieving better service delivery and patient care.” (Integration Lead)

The perceived increases in joint working may not have been due solely to the Integration Lead roles. As ICBs and PCNs mature, it may have been a natural progression to work more closely with community pharmacy because this is part of the remit of these networks. The launch of Pharmacy First in 2024 was a lever for community pharmacies and practices to work together. Local areas also have a range of other collaborative initiatives underway. We may therefore have expected to see some improvements over the year, whether or not Integration Leads were in post.

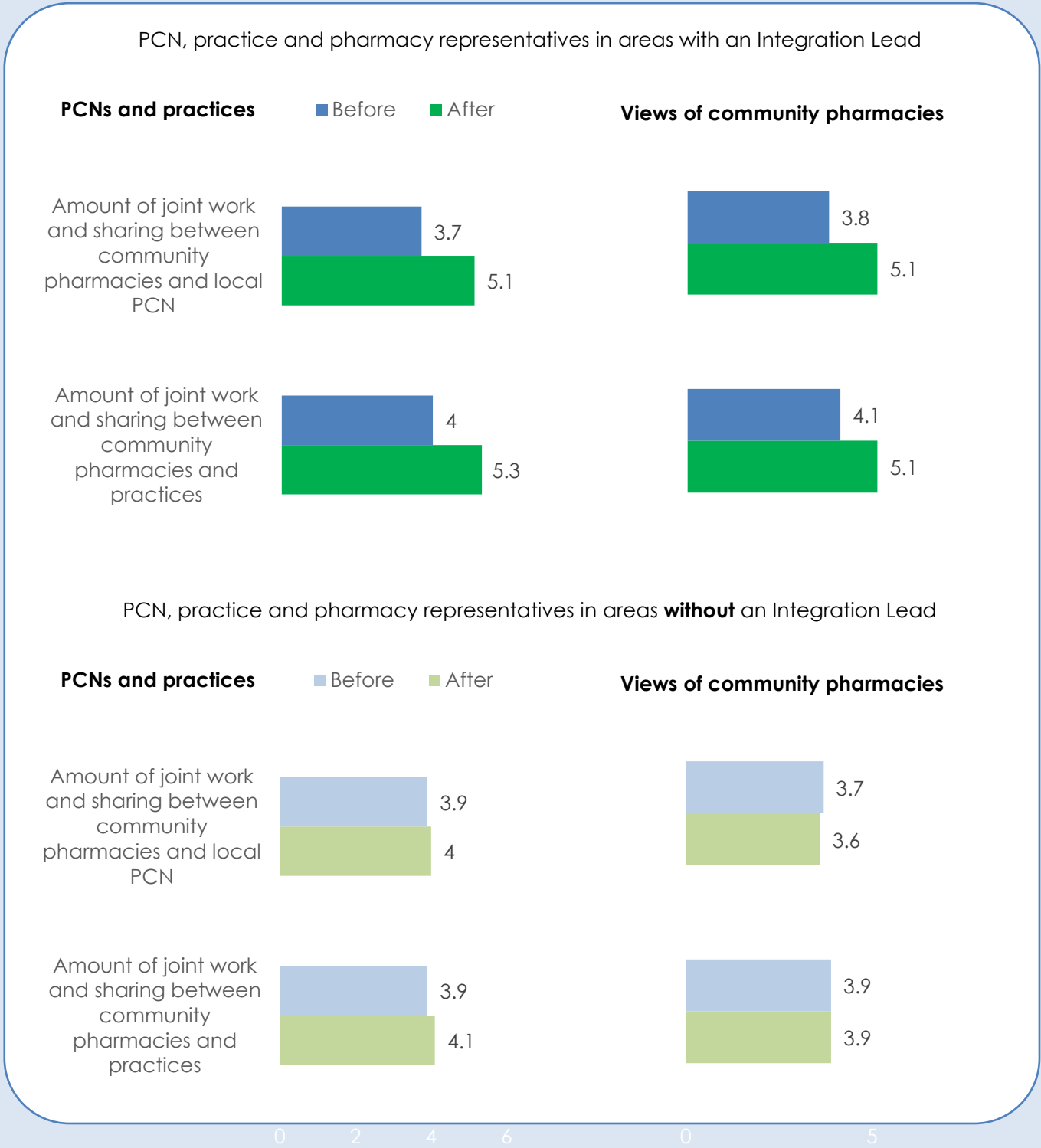
However, there are two things that suggest that Integration Lead roles boosted collaboration more than would otherwise be the case:

- In interviews, representatives from PCNs, practices and community pharmacies often explicitly talked about the role Integration Leads played in supporting joint working. When an independent interviewer telephoned or visited to ask about joint working in general (without saying they wanted to talk about Lead roles), about **half of participants mentioned the Integration Lead’s name as an example of joint work without any prompting.**
- In interviews and surveys, representatives from areas that did not have an Integration Lead were less likely to say they had noticed much change in collaboration or communication over the past year (Figure 9). The difference in survey feedback between areas with and without a Lead was statistically significant, meaning it probably did not happen by chance.



"I was a bit cynical before. You know, pharmacies are businesses. They are competing for patients and funds. I thought they were just trying to get feet through the door for the wrong reasons. But talking to [Integration Lead], putting a face to the name and getting to know them as a person brought home that pharmacists know what they're talking about. They have the interests of patients at heart. Working with them can help my practice manage demand and give patients good outcomes. It's early days, but my opinion is changing. We're doing more together." (GP)

**Figure 9: Average rating of how much joint working there is (out of 10)**



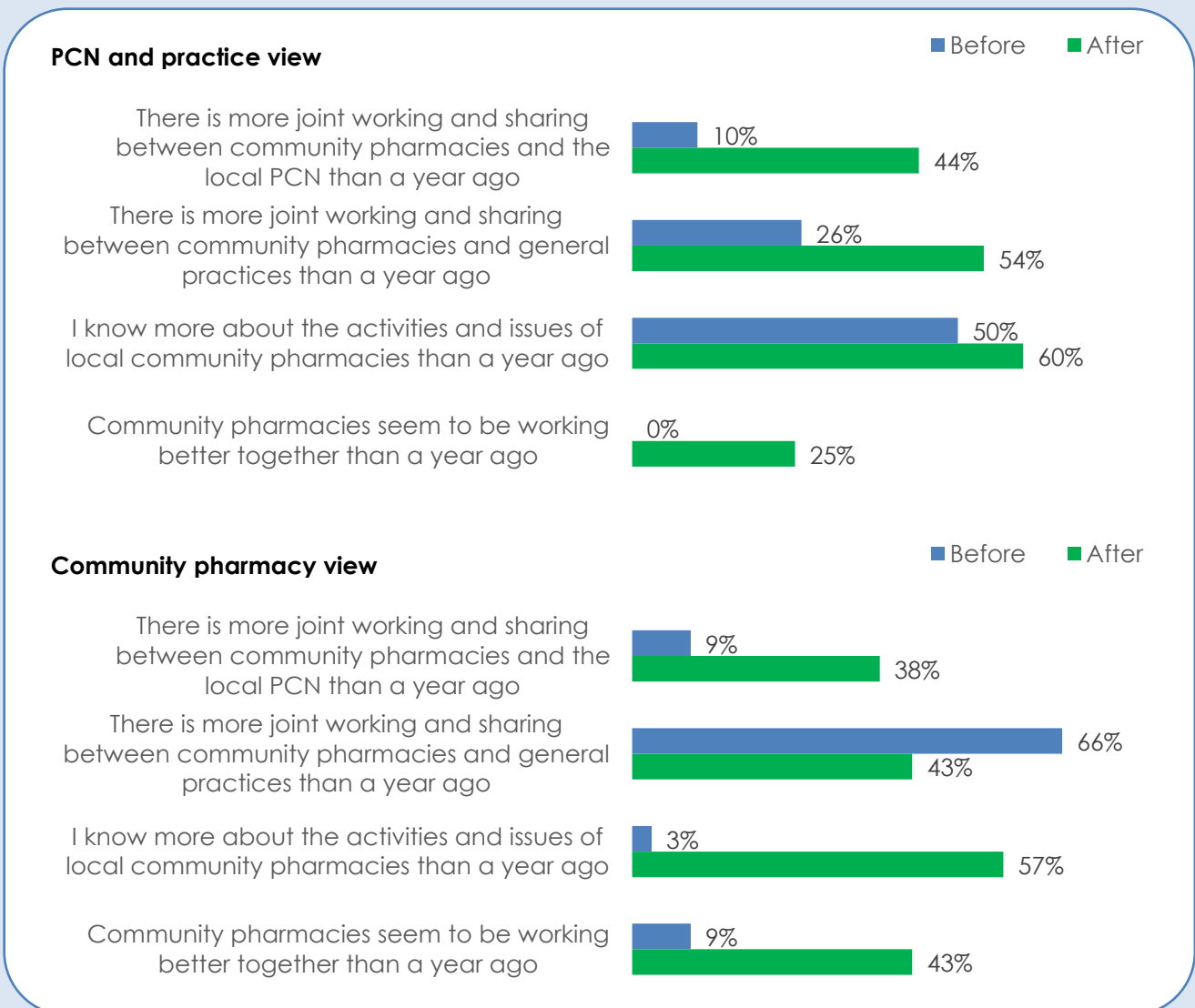
Note: The survey asked people to rate the amount of joint working on a 10-point scale, where 10 was highest. In areas with an Integration Lead, 76 pharmacies answered at the start and 58 at the end of the test period. 78 practice and PCN representatives answered at start and 110 at end. In areas that did not have an Integration Lead, 67 pharmacies answered at the start and 112 at the end. 50 practice and PCN representatives answered at the start and 67 at the end.

“There is less negative competition with other pharmacies because we all know the other people in person now, not just their pharmacy name. We don't mind sending patients to other pharmacies now. Also, it is as though we can speak with one voice to local practices now. Me and people from other pharmacies call up [Integration Lead] with our concerns. [The Lead] then liaises to improve things. All pharmacies now email the GP dispensary team with our stocks rather than referring a patient back to the surgery if a medication is not available. This has all just happened over the last six months. We're feeling more like a team.” (Community pharmacist)

“Our nurse triage team at the practice were keen to make Pharmacy First referrals. The Lead met with them and we changed our pathways as a result of that conversation. The triage team are now making referrals regularly. That is a concrete change to how we work together that wouldn't have happened, at least not as fast, without the Lead.” (Practice manager)

“In our area people are working together to offer services. In some places the Lead has engaged with the PCN to such a level that they are creating local agreements for referring patients to community pharmacy for hypertension. Another Lead got PCN practices to book patients in for blood pressure checks and then they text patients telling them to go to the pharmacy for the check. Practices book patients in via SystmOne, direct for the pharmacy.” (Local pharmacy committee representative)

**Figure 10: Perceptions of collaboration in areas with an Integration Lead (% that agreed)**



Note: Percentages are the proportion that agreed with each statement. 76 pharmacies answered at the start and 58 at the end. 78 practice and PCN representatives answered at start and 110 at end.

**Improved joint working was not reported across all organisations or areas.** In particular, general practices often said that they were not aware of the concept of Integration Leads, did not know who the Lead for their area was or had never met them.

Some practice representatives had sought out their Lead, but been dissatisfied with the interaction or the scope of the role (saying the Lead could not assist with what they wanted). It is important to note that the remit of the Integration Leads was not necessarily to contact every individual practice. Leads were encouraged to work with PCNs as a conduit to practices.

However, even so, the variation in people's experience of the Lead role is worth noting. We describe factors that may have helped and hindered perceptions in the final section.

"I didn't see any value from having a Lead role. I'm in the PCN and also at a practice. The Lead didn't get in touch. I heard about them at a meeting so I knew the role was happening but they didn't make contact at all. After months of waiting, I ended up tracking them down to have a conversation because I was concerned about how a couple of pharmacies were working. They were turning away patients we sent to them, and there were also issues with medicines always being out of stock and taking a long time to fill prescriptions. The Lead just said there was nothing they could do and it wasn't in their remit. So I thought this was just a waste of time and money." (GP)

"Some PCN / GP stakeholders have said they didn't see the value but pharmacies told us they felt more connected to each other. A role like this can't be all things to all people, but there may have been more benefits for pharmacies in the first year than practices or PCNs. Leads need to establish the relationships first before we can see changes to services. The short duration of the role (1 year) and perception of a previous 'old' role hindered what could have been achieved and influenced some negative PCN and practice views. Using the title 'primary care lead' might be better than 'pharmacy lead' when trying to engage with GPs. I mean, still having a pharmacist doing the role. The title of pharmacy lead might also explain some of the dissatisfaction we heard from GPs as they didn't see the point or thought it was not for them." (ICB representative)



## Referrals to community pharmacy

We wanted to see whether stakeholder perceptions of joint working translated into changes in referrals to community pharmacies. It is important to emphasise that increasing referrals was **not a formal aim** of the pilot period and not something that Integration Leads were explicitly tasked to do. This is potentially a marker of increased collaboration in future.

NHS England collates official statistics about referrals to community pharmacy. Since some of the ICBs tested Integration Lead roles in only selected PCNs we wanted to compare referral rates in PCN areas that did and did not have Integration Leads. However ICBs did not have this information available to share. This is something that ICBs could compare in future.

Hertfordshire and West Essex did have data available about referrals to pharmacies. However every PCN in this ICB had an Integration Lead so we were not able to compare PCN areas with and without a Lead. Figure 11 shows the number of referrals to community pharmacies over time, before and after Integration Leads were in post.

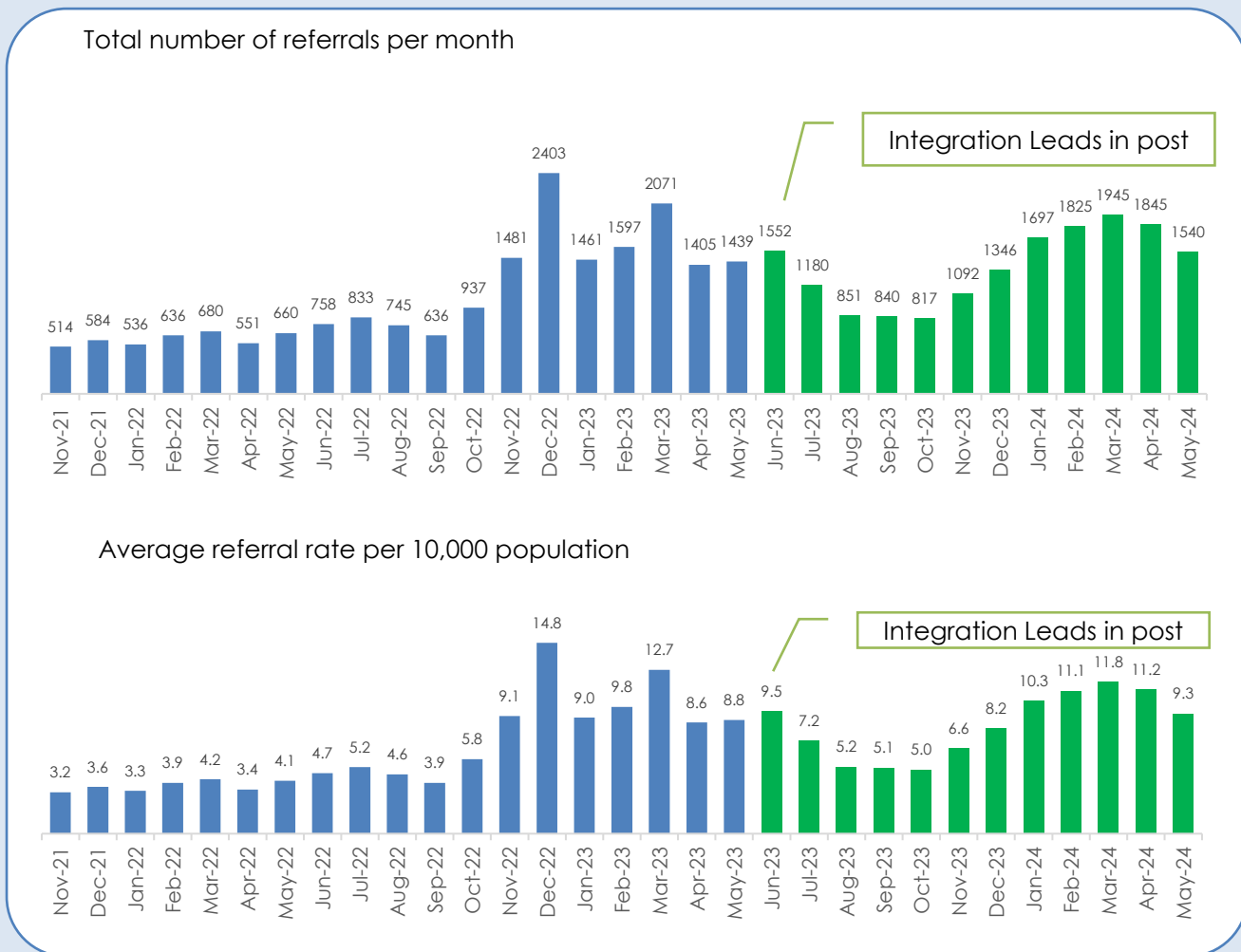
There are many caveats with this data. Firstly, only activity recorded on the PharmaOutcomes system is included. Secondly, data for some months is only for practices using the EMIS system, not SystmOne. And thirdly, any changes cannot be attributed solely to the Integration Lead roles, especially as Pharmacy First began being promoted in 2024. However, the broad trend is for referrals from practices to community pharmacies to have risen slightly when Integration Leads were in post.

- In the 23/24 financial year there were 15,989 referrals from general practices to community pharmacies recorded in Hertfordshire and West Essex, an average of 1,332 per month. Integration Leads came into post in June 2023 of this financial year. This compared with 14,133 referrals in the 2022/23 financial year, an average of 1,178 per month (Figure 11).
- Between June 2023 and May 2024 when Integration Leads were in post, there were 16,530 referrals to community pharmacies recorded, an average of 1,378 per month. This is a 5% increase in the total amount of referrals received in the same period the previous year. The average number of referrals per month increased from 8.1 per 10,000 population between June 2022 and May 2023 to 8.4 per 10,000 population when Leads were in post between June 2023 and May 2024. Changes in referral rates were most marked in the months after Leads had finished their training commitments and may have been able to devote all their funded time to liaison activities.
- Currently, each month there are an average of about 62 Pharmacy First consultations per 10,000 population (whether referred by general practice or not) in Hertfordshire and West Essex. This is a higher rate than some of the other East of England ICBs that did not have Integration Leads in every PCN area (Table 2). However, Cambridgeshire and Peterborough and Mid and South Essex ICBs had about the same rate of Pharmacy First consultations per month per 10,000 population as Hertfordshire and West Essex, even though these areas did not have Integration Leads in every PCN.

Pharmacy First is too new to use to track the impact of Integration Leads - and Leads were not tasked with increasing referral rates in their first year. The data available show the potential to compare rates of referrals in areas that do and do not have Integration Leads in future.



Figure 11: Referrals from general practices to community pharmacies in Hertfordshire & West Essex



Note: Data are from a dashboard created by Hertfordshire and West Essex ICB. Data are based on PharmaOutcomes, which is often updated 2-3 months in arrears. The numbers are referrals via the previous Community Pharmacist Consultation Service (minor illness and urgent repeat medicines supply pathways) and Pharmacy First programme. Data for January and February 2024 are based only on practices using EMIS, not SystmOne because NHS England had not yet made all data available.

Table 2: Pharmacy First consultations in East of England ICB areas

	Bedfordshire, Luton and Milton Keynes	Cambridgeshire and Peterborough	Hertfordshire and West Essex	Mid and South Essex	Norfolk and Waveney	Suffolk and North East Essex
<b>Total number of Pharmacy First consultations each month (whether referred by practices or not)</b>						
Feb 2024	4087	4826	9001	7565	2876	4440
Mar 2024	4800	5680	9496	8458	3737	4620
Apr 2024	4736	5594	9684	8150	3386	4797
<b>Average Pharmacy First consultations each month per 10,000 population</b>						
Feb 2024	40	52	59	59	27	44
Mar 2024	47	61	63	66	36	46
Apr 2024	47	60	64	63	32	48

Note: Numbers are the total number of Pharmacy First consultations pharmacies claimed for earache, impetigo, infected insect bites, shingles, sinusitis, sore throat, uncomplicated urinary tract infections in women, urgent medicine supply and minor injury referrals. Pharmacy First data became available from the NHS Business Services Authority from February 2024. Hertfordshire and West Essex ICB area had Integration Leads in every PCN. The other East of England ICB areas had Integration Leads in only 2-5 PCNs. The ICB areas have different population sizes and different numbers of pharmacies so it is not valid to compare numbers across areas, but the bottom set of numbers provides the rate of consultations per 10,000 population. Population numbers were taken from the Office for National Statistics 2023 health geographies dataset.

# Other impacts

In interviews and survey forms, stakeholders suggested that having Integration Lead roles had several other benefits, including:

- increasing the **visibility of community pharmacy** within ICB teams, local authorities and training hubs (not solely PCNs), rather than seeing 'primary care' as meaning mainly general practice
- at system-level, recognising the key role that **local pharmacy representative committees** and other stakeholders can play in supporting the success of integration initiatives
- increasing awareness among Leads and wider community pharmacy organisations about the **role of the ICB** and how healthcare is structured and managed locally
- reducing the number of **queries** about community pharmacy issues received by ICBs, because Leads were becoming known as contact people who could handle these enquiries
- taking part in events for **members of the public**, to raise awareness about the range of support that community pharmacies can offer (e.g. public health events)
- having the same training for Leads across most East of England ICBs put Leads in contact with those working outside their ICB area. Leads set up a WhatsApp group to keep in touch with others **across the region**
- supporting pharmacies and building resilience as they move to a new **model** of providing services

"From an ICB perspective, having Leads has been good for helping community pharmacy understand what an ICB is. ICBs have just recently taken responsibility for commissioning pharmacy. We're all on a learning curve so the Leads are helping to reorientate pharmacy providers to how things are managed and commissioned now." (ICB representative)

"We did an event where the Council promoted that people could have their blood pressure measured at pharmacies. We had the logos of all pharmacies on the promotional leaflet. That was a great change, seeing all pharmacies working on something together. The Council now realises that pharmacies are a force that can be relied on to deliver – so we can be commissioned as a group for public health and other initiatives. It is changing how pharmacies are viewed as a collective." (Integration Lead)

"Leads have developed a lot themselves, growing in confidence and knowledge. They see outside of their own businesses now and understand the wider system. Their knowledge about how things fit together is inspiring others within the ICB, and we're thinking of how to build that understanding across other professions and sectors. It's a model that we could apply more widely." (ICB representative)

"Pharmacy is a tough job. The model is changing from being in the dispensary to being out the front offering frontline services. Pharmacists now need to be more proactive and engage with patients and practices to offer services. My role as a PCN Lead helps to boost pharmacists' confidence about the new roles they need to take on. I'm a direct conduit to the PCN and practices. There are lots of barriers stopping practices referring to pharmacies and my role is to help to break these down. It's supporting integration between practices and pharmacies and it is also about building the resilience and confidence of pharmacies and the quality of services they can provide." (Integration Lead)

No-one suggested any negative impacts, though some questioned the return on investment.

Two PCNs that were not taking part in the pilot were inspired to hire an Integration Lead themselves, using their own funding. Box 3 describes the experience of one of these PCNs.



### Box 3: Feedback from a PCN that used their own funding to hire an Integration Lead

#### What a PCN manager says

"The [Network Contract Directed Enhanced Service](#) (DES) upon which PCNs are founded is about increasing capacity and impact in primary care. We know that we need to work in an integrated way, work at scale and focus on population health to see a real impact. We realised that our PCN had limited experience working with community pharmacy. We wanted to truly collaborate not just 'do to' pharmacy. Therefore our PCN Board approved a proposal for [an Integration Lead] based in community pharmacy to work with our 6 practices.

We used some of our [Capacity and Access Improvement Payment](#), which all PCNs get to support improved access to primary care. The [Integration Lead] role fits perfectly with the remit to improve access. We're focusing the role on helping to divert patients from general practice by increasing use of community pharmacy. Our vision is to help patients to go to the right place for help.

We looked at data about which pharmacies our patients mainly used and approached some of them for expressions of interest. We provided an induction but no special training. We meet regularly with the Lead to plan and discuss progress. He's one of our team. He's a core member at our PCN meetings, helping us to understand the vital role of community pharmacy and shape plans. We think this is increasing the number of Pharmacy First referrals. It was initially a 1-year role but we are so happy with progress that we're extending into a second year."

#### What an Integration Lead says

"I was directly approached to apply for the role. I was motivated by wanting to help raise awareness of what pharmacy can offer so our local businesses can keep going. We set a few goals together to get pharmacies involved in the PCN and understand what the barriers are to working together. The first thing I did was to get pharmacies together. I compiled their contact numbers so GPs could get hold of them, and also a list of what services they offer. We set up a WhatsApp group for pharmacies. I also surveyed pharmacies to find out their needs and concerns.

When Pharmacy First launched my role began to focus more on helping to increase patient access to pharmacies. I feel like I am making a difference. I created a community pharmacy referral guide for practice call handlers / receptionists. I also ran a virtual training session for pharmacies about Pharmacy First. We're going to audit the number of referrals next.

I attend the PCN meeting every month. I try to help practices to think about things in different ways. Pharmacies can't single-handedly reduce demand for GP appointments. That needs all partners working together. I find it important to have an end goal that I'm aiming for with my role – so I'm focused on increasing referrals."

#### What a general practice says

"We have a wonderful passionate Lead. He has trained our reception teams about how to refer for Pharmacy First and he troubleshoots if there are any issues with referrals. Pharmacy First has potential but I don't think it will happen well by itself. Having a pharmacist helping to implement it across all the practices in our PCN means that we are getting some consistency for patients, practices and pharmacies. We are actively making it work. Having a Lead is helping to develop relationships between the practices and pharmacies. He is not imposed from elsewhere. He is part of the PCN staff. It feels like he's one of us and we're all in this together."

#### What an ICB representative says

"This is an innovative PCN with strong leadership. What set this model apart is that the Lead was integrated into the PCN team, not trying to influence from outside. The PCN decided what they wanted to achieve. The PCN manager and clinical director did interviews. Then the lead reported to them once selected. The Lead was seen as part of the PCN. There was some extra support such as mentoring by the ICS pharmacy clinical lead, but what makes this model interesting is that the PCN owned it and the Lead was on their payroll."

# Costs

This pilot was funded by the former Health Education England which provided funding for training as well as Integration Leads' time (at a fixed rate of £320 per day). ICBs, training hubs and local pharmacy committees provided additional resources to support and manage the roles.

Table 3 shows the costs of implementing the pilot in Hertfordshire and West Essex as an example of what it cost to roll out Integration Leads across an entire Integrated Care System. This ICB chose to allocate specific funds for project management because it was recruiting and managing more than 30 Integration Leads as well as supporting administration of the East of England pilot as a whole.

Taking account of training and development costs, programme management and reimbursement of Leads' time, it cost an average of about £8,000 to implement each Integration Lead for the first year. In subsequent years, the cost may be reduced to cover just fees for Leads' time (about £7,000 per Lead), with any ongoing support and management provided as business as usual through existing ICB roles.

In Hertfordshire and West Essex there has been a 5% increase in referrals from practices to community pharmacies whilst Integration Leads have been in post. This is more than 700 additional referrals compared to the previous 12-month period. It cannot be assumed that this increase was all due to Lead roles. Nor might all the referrals otherwise have been seen by GPs. However, as a rough [approximation](#), the additional referrals are worth about £32,000. Increased referrals are not the only way to judge the value of Lead roles, but this gives some indication of the scale of potential savings in this area so far.

The costs associated with other ICBs in the pilot were like those in Hertfordshire and West Essex, at an average of about £7,000 per Lead. This covered both fees for Leads' time and training. Other ICBs did not have additional project management costs. They managed the pilot within existing staffing because they tested Leads in a small number of PCNs rather than across the whole geography. However, they also paid a set fee rather than only time that Leads claimed.

In the small number of PCNs that hired an Integration Lead from their own funding, outside the pilot process, the costs were solely for the Lead's time. There was no extra training funded.



**Table 3: Annual cost incurred when setting up Leads roles across a whole Integrated Care System**

	<b>Cost</b>
Training, facilitation and venue hire	£44,000
Fees for Leads' time (up to 20 days per Lead)	£161,000
Project management support	£33,000
Total annual cost	£238,000
<b>Average annual cost of the pilot per Lead role</b>	<b>£7,700</b>

Note: Figures have been rounded. The average cost is based on 31 Leads retained through the year. In Hertfordshire and West Essex, Leads claimed for the hours they worked (up to a maximum). In most other ICBs, the Integration Leads were paid a set fee per month and they all took part in the same leadership training (not separate training per ICB).

# What we learnt



## Lessons

This section describes themes in stakeholder feedback about what helped and hindered implementation of the Integration Lead roles. It is not meant to critique or detract from the significant work and passion of individual Leads and other stakeholders, but to celebrate things that worked well and describe lessons that may help to strengthen the approach if it continues.

### Feasibility

Feedback from stakeholders suggests that:

- It was feasible to implement Integration Lead roles in terms of recruiting, training, retaining and supporting people.
- It was feasible to have people working in community pharmacy take on part-time Integration Lead roles that were accepted by other pharmacies, PCNs and practices.
- It was feasible for these roles to focus on building communication and collaboration.

In other words, the scope of the role, implementation and processes were all feasible within the timeframe and resources available.

There were challenges and areas for development in each of these areas (described on the following pages), but overall it was possible to implement the model as expected.

### Perceived value

There were many positive comments from PCNs, practices and community pharmacies about the potential of Lead roles as well as stories about practical things that Leads had done to build relationships and support joint working. It is not yet clear whether this will translate into greater uptake of services in community pharmacy or changes in care pathways to benefit local populations. But the pilot achieved what it set out to do in the first year, which was building knowledge, communication and engagement.

The launch of Pharmacy First was a good catalyst to spark conversations.

*75% of stakeholders in PCN areas with a Lead surveyed at the end of the pilot suggested that it was worth continuing roles like this in future.*

Importantly though, there was wide variation in the perceived value of the roles. One quarter of stakeholders in PCN areas with a Lead did not believe that this was a worthwhile investment or had potential. It appeared that stakeholders who were less positive were dissatisfied with their experience with individuals rather than the concept of the role itself. Stakeholders with less positive perceptions tended to report:

- a lack of contact with their Integration Lead (no contact or not as regular as they would like)
- Leads not being able to act on or solve issues as they hoped

The Leads only had an average of 3 funded hours per week (or 2 hours per week once training time is considered). They also have busy roles in community pharmacies. So it is not surprising that Leads did not have capacity to do everything that stakeholders hoped. **It is important to be realistic about what can be achieved within 2 days per month.**

However some of the dissatisfaction was around a lack of consistency in how roles were implemented, such as when a Lead in one PCN area would say that something was outside their remit whereas a Lead in another area would be doing that same activity. An example is understanding the reasons why pharmacies returned referrals from general practices. The lack of consistency in what Leads were doing or saw as their role is important because it led to strong views from some stakeholders about a lack of perceived value.

Stakeholders that were dissatisfied or thought Lead roles were 'a waste of time and money' often said, when questioned further, that it would be helpful to have someone to act as a 'voice of community pharmacy' or a conduit to get information to and from community pharmacy, so it was not the concept of the role that they disagreed with, but the way it was being implemented.

PCNs and practices did not know where they could report any issues around the roles to. There was no clear accountability structure or 'line management'. This led to further frustrations.

## Recruitment

All the ICBs publicised the Integration Lead roles and were able to recruit to them, but there were relatively low numbers of applications in most areas. People who took Integration Lead roles said that the job description and other communication could have better described what Leads would do.

ICBs recommended starting recruitment earlier in future and allowing plenty of time. It worked particularly well to approach pharmacists directly to invite them to apply. Local pharmacy representative committees were helpful here.

Most of the Leads were pharmacists. Some stakeholders thought this was important because having a clinical background gave the Leads a degree of status and respect in meetings with other pharmacists, GPs or senior managers. However other stakeholders said that most of the work was about building relationships and communication, so detailed clinical knowledge was not necessary. In the pilot only a small number of Leads were pharmacy technicians. These Leads and the stakeholders they worked alongside were just as favourable about impacts as Leads who were pharmacists, but the numbers are too small to judge whether being a pharmacist made a difference.

The ICBs' processes for interviewing candidates appears to have worked well, because Leads and stakeholders generally felt that the people appointed to Lead roles had the right aptitudes, skills and attitudes. Some Leads had a lot of experience representing pharmacy, attending policy meetings or engaging at senior level. Others did not have this type of experience, but were good communicators and passionate about making a difference. Some Leads were employed in large chain pharmacies, others came from small independent businesses. Leads' effectiveness did not have a clear relationship with their experience or environment. Those with limited experience in leadership roles were sometimes described as very effective by their PCN and neighbouring pharmacies.

## Training

There were three separate leadership training programmes run across the East of England. Hertfordshire and West Essex commissioned a training programme for its Leads due to the large number of Leads it recruited. All the rest of the ICBs combined to take part in a separate programme (split into 2 cohorts). It would have been possible to use the same training provider, but the ICBs selected providers separately based on what they felt would best serve local needs. One ICB finished recruiting their Leads after this training programme began so set up their own training arrangements.

Regardless of which provider was used, the content was similar, covering communication and leadership skills. There were differences in the number of sessions and the format. For example, one programme had e-learning modules for Leads to watch plus a smaller number of online and in-person sessions. Another programme had monthly online sessions with some face-to-face sessions. Both programmes had some one-to-one support sessions or coaching.

There was no difference in the perceived usefulness of the training by Leads, regardless of which programme they took part in. There was also no difference in the amount of change in Leads' self-reported knowledge and confidence at the end of the year according to which training programme they did.

The pilot devoted about one third of Leads' total funded time to training. Some Leads valued the content greatly. Others suggested that it was not specific enough for their roles or that it repeated content that they already knew. This is in line with the varied experience the Leads had. Some Leads felt it would have been more effective to do a training needs assessment before commissioning generic training, to get the best value.

The highest rated aspect of the training was the opportunity to meet with other Leads and facilitators to discuss progress and get peer support. It was the act of meeting others for support rather than the formal course content that Leads found most useful. Some suggested that in future new Leads could pair up as 'buddies'.

The small number of PCNs that hired Integration Leads themselves, outside the pilot, did not have access to the training programmes or peer support. These PCNs and their Leads did not report any gaps in knowledge or confidence. Wider stakeholders were very positive about the work of these Leads and said that they had helped to boost collaboration – which suggests benefits may be possible from Lead roles without such extensive training. This is not to say that formal training is not useful, just that it is difficult to differentiate the benefits from the wider networking opportunities it offered (and in-house orientation).

In future, if there is not ringfenced funding available for training, it may be helpful to give new Integration Leads access to pre-existing e-learning resources plus opportunities to meet with others regularly (monthly for the first three months then quarterly perhaps). Leads could be supported to facilitate a **community of practice** for themselves. Many stakeholders would like to see Leads and practices trained side-by-side as well as shadowing opportunities, where Leads observe at practices and practices observe at pharmacies. They also wanted more training about system context and strategic working.

Stakeholders felt that Leads' development needs should be considered so ICBs can continue to provide Leads with opportunities to enhance their strategic thinking and take on roles on other committees and groups.

“Leads had basic leadership training but now we need to look at onward development to give them more strategic oversight, not more of the same. We also should give them more strategic roles so pharmacy can get on a more equal footing with general practice in terms of being part of leading commissioning and service development in future. ICBs need to think through the development journey for the Leads depending where we want them to end up.” (ICB representative)



## Retention

95% of the Leads stayed in their roles for the year. Those who did not continue cited an inability to juggle the role with their day-to-day work commitments.

However it is not certain that all Leads continued to be active during the year, because about one quarter did not provide records of any activities they did. There was a drop off over time. For example, 90% of Leads recorded some activity in the first quarter. By the final quarter of the pilot only two thirds recorded some activity. The fact that Leads did not report their activities does not necessarily mean they were inactive, but it does signal that they were not fulfilling their role description in full. It also makes it difficult to say whether they were fully retained.

Most of the Leads wanted to continue their role if there was an opportunity to do so after the pilot period ended. Some were continuing informally after their paid role ended, such as continuing to meet socially with pharmacies, run webinars or share information via WhatsApp.

Some ICB, training hub and local representative committee stakeholders suggested that it is important for morale and retention to support and value people in new roles, especially when roles are part-time and challenging. Leads often voiced concern about whether they were making a difference and whether stakeholders knew about the role. Some ICB colleagues said it was important to give Leads positive feedback regularly so they know they are valued and making a difference – and as a way to keep people motivated and in post.



## Time issues

It took time for Leads to gain confidence in their roles. It is therefore important that future iterations allow enough time for roles to embed and do not make judgements about impacts based on unrealistic time periods or targets. This pilot allowed a full year for developing and embedding the roles, and set realistic ambitions (improved communication and engagement rather than largescale changes to referrals or pathways). This is something that the pilot did well. It did not set up the roles for failure with potentially unrealistic targets from the outset.

This is particularly important given the historical context and funding driving competition rather than collaboration – both between pharmacies themselves and between practices and pharmacies. It takes time to build trust and relationships when organisations have been used to competing. Some Leads reported that there was some suspicion of their role at first, particularly from larger organisations rather than smaller independent providers.

Another key issue around timing is Leads' capacity to do the role. There were two elements around capacity:

- Leads were funded for an average of 2-3 hours per week. This is not a lot of time to be in touch with all pharmacies, PCN stakeholders, practices and others, and to support meaningful change. [Most Leads reported that the role needed more than their funded hours.](#)
- Leads were juggling busy workloads in their pharmacies, and were not always able to prioritise their activities as a Lead. They were also not always available for meetings at times that suited other stakeholders.

Some Leads set aside specific hours each week or month to work on integration activities (such as Thursday afternoons). However, most found that they needed to do tasks more flexibly, both to fit in with the availability of other stakeholders and in line with fluctuating demands at their pharmacy. Leads said it would be helpful to describe this better in advertisements and job descriptions.

Another common suggestion was to provide Leads with a checklist or workplan of expected activities such as setting up a WhatsApp group, attending PCN meetings, meeting with the PCN clinical director once per quarter etc. This would be more like a menu than a 'must do' recipe because different areas have varying needs and it is important for Leads to have some autonomy. This was a pilot so steps that supported success were not necessarily known in advance. However now information about key activities is available, stakeholders felt it would be useful to provide a checklist of potential steps for any new Leads to adapt.

## Engagement

Leads reported varying levels of buy-in and engagement from stakeholders such as PCN clinical directors, community pharmacies and general practices. Some were eager to engage; others were not. Leads were sometimes told that independent businesses such as pharmacies and practices did not see anything 'in it for them'. Or practices reportedly viewed pharmacists as 'business owners' rather than clinicians with patient interests at heart. Stakeholders generally did not think there were strong levers to drive engagement.

There is no easy solution. Some Leads focused primarily on working with those who were most ready to engage. The rationale was that this would build momentum and relationships so others would eventually come on board. Others focused on trying to engage with those who initially seemed less interested because they felt this would have a larger impact in the longer term. Targeting practice managers was often a successful 'way in'.

Many Leads said they would have liked to spend more time during training and support sessions considering ways to encourage stakeholders to engage.

Leads said that it worked particularly well when they were able to visit a community pharmacy or practice. They felt that face-to-face meetings, even if only short, helped to build relationships and trust better than telephone or video calls.

Leads found that WhatsApp messages or text messages often were more effective for sharing information with community pharmacies than email messages.

Some Leads focused on building relationships across community pharmacies initially, so they could understand issues outside their own organisation and feel more confident about representing the wider group. Others simultaneously pursued contact with PCN team members and practices so they could understand issues from a wider perspective and have enough time to build relationships during the pilot period.

Most Leads found it easier to engage with pharmacies, though there were still reports of fears over competition. Some stakeholders perceived that certain Leads were talking on behalf of their own pharmacy rather than taking steps to engage widely and represent a broader pharmacy voice. Part of this might be due to difficulties Leads had gaining buy-in from colleagues, but it may also signal areas to develop in terms of the role description and onward training about representing the wider sector.

Many Leads mentioned that it would have been helpful to have ICBs introduce them to PCN clinical directors and other key stakeholders and to make it clear that ICBs wanted PCNs to engage with Leads (rather than individual Leads trying to introduce and justify the role themselves). This was both for practical purposes, but also to build trust and credibility.

*"There is a significant lack of knowledge and scepticism regarding the credentials for community pharmacists to take a wider clinical role within the NHS... There seems also to be a trust issue which seems to lurk in the background, is rarely openly articulated but nevertheless needs to be addressed head-on because such mindsets are likely to drive negative behaviours to the detriment of the profession. An individual pharmacist (Integration Lead) can't tackle that alone." (Integration Lead)*

Various stakeholders suggested that in future it would be helpful for system partners to develop a list of important contacts and potential supporters to introduce Leads to early on. For example, some training hubs have clinical ambassadors for community pharmacy/primary care.



## Geographic scope

One of the most common reflections from stakeholders was about whether PCNs were the appropriate geography for roles such as this. Many suggested that it may be more practical and worthwhile for Integration Leads to work across the geography of an Integrated Neighbourhood Team, locality or ICB Place.

The rationale was that PCN boundaries do not necessarily tie in with how pharmacies work. Embedding pharmacy within the newly emerging Integrated Neighbourhood Teams was seen as more strategically valuable than trying to work with existing PCNs, which stakeholders said had some legal challenges around including pharmacy as full partners.

"The role would probably have more impact if it was based at neighbourhood level, not PCNs. PCNs are in a restricted area, whereas pharmacies work across areas. Plus in PCNs, the Lead needs to talk with the clinical director and hope that they will disseminate to general practices. If a clinical director doesn't roll things out to practices or engage then this is a roadblock. Whereas with neighbourhoods or localities, the boundaries are slightly bigger and there are a wider range of stakeholders so it is more patient orientated. Neighbourhood teams are just developing so it is the right time to get pharmacy in there." (ICB representative)

"When making decisions about next steps, need to think about the big problem facing the NHS in terms of capacity and whether Leads will help address that through building community pharmacy capacity and moulding patients' behaviour in the longer term. So decisions about whether to have the role and which geography to cover should be based on what will best support with demand management in primary care. I think that is at a Place or locality level, not PCN." (Integration Lead)

"PCNs have legal and governance requirements so I'm not sure its right to say pharmacy should be full partners in PCNs. Localities might be better places for Leads to affect integration." (GP)

People acknowledged that it may be difficult for Leads funded for just 3 hours per week to cover a larger geographic footprint. However stakeholders thought this would be feasible if Leads were not expected to have individual contact with practices and all pharmacies (for example focusing on group meetings). On the other hand, some of the most impactful work reported during the pilot occurred when Leads did one-to-one work with practices and pharmacies (such as visiting individual pharmacies or training the reception team at a practice).

There is not necessarily one right footprint. PCNs are different sizes and work in varying ways. Stakeholders suggested that if Lead roles are continued, thought should be given to the most appropriate geography rather than unquestioningly continuing with PCNs.

At the end of the pilot, two ICBs committed to fund Lead roles for another year (in one case using underspend from another programme and in the other using Service Development Funding (SDF) that NHS England provides for ICBs). Both ICBs decided to use a locality approach rather than hiring a Lead for each PCN.

Leads commented that they would like to be reimbursed for travel costs. Travel costs may be greater with a larger geography to cover.



## Management

In terms of feasibility challenges, it took significant management time to implement the model, especially when recruiting Leads simultaneously for every PCN in an ICB area. In this case, dedicated management and administrative time was ringfenced.

ICBs that started by testing Integration Leads in a smaller number of PCNs were able to recruit and support Leads using existing management capacity. However, whether implemented in some or all PCNs, stakeholders reported that a lack of management capacity limited the speed of progress and the amount of ongoing support and interaction ICBs or their partners had with Leads.

Leads often said that they would have valued more centralised infrastructure or that they found it helpful when ICBs provided support such as:

- publicising the role at meetings and via newsletters or letters so stakeholders knew that it was sanctioned by the ICB
- sending the role description and expectations to PCNs, so they were clear about the purpose and the engagement expected from them
- having a clear governance structure so Leads and PCNs had accountability routes
- making direct introductions to PCN, practice and other key stakeholders
- providing templates for presentations and documents to share with practices and pharmacies rather than each Lead having to make their own
- providing data about the PCN, practices and pharmacies regularly, such as official statistics about the number of referrals to pharmacies. Information is available online, but it would be more efficient for this to be compiled centrally and shared than for each Lead to spend time compiling it
- regular opportunities for groups of Leads to check in with the ICB (or similar) about progress, to escalate concerns and identify potential solutions to barriers

These are simply examples to show that getting the best from Lead roles may require ongoing management capacity. The need for support does not end after Leads are recruited.

Future implementation may need to consider the personnel resources needed for ongoing support, particularly if external trainers are not commissioned to provide coaching and regular check ins. Some of this may come from individual PCNs, ICB Places or Integrated Neighbourhood Team areas, but having consistency across the ICB (or the region) may be useful since this is an emerging role.

There are also opportunities for economies of scale if all ICBs use the same template for promotional materials, contracts, information packs and similar. ICBs have specific contextual information and relationships that they would want to incorporate, but each ICB probably does not need to generate completely different processes and documentation.

In terms of payment, some ICBs paid Leads a set fee. Other ICBs paid for hours worked, up to a maximum annual amount. It was most efficient when Leads were paid a set fee. There would need to be checks in place to make sure that the desired outcomes are being achieved. In this pilot, using timesheets did not support quality control. For example, some Leads claimed for 16 hours of work, but only documented sending one email or attending one meeting that month.

Some Leads were reimbursed for travel costs and others were not. This was a source of contention, with Leads suggesting that there should be a travel allowance because some training was face-to-face and because they thought in-person visits to practices and pharmacies were more effective for building relationships.

## Strengths in ICB areas

Each ICB implemented the pilot in a way that fit with its local needs and capacity. It is not helpful to comment on whether some ICBs were more 'successful' than others because each area did things in a way that reflected local ways of working and capacity. There were no significant differences in stakeholder perceptions of outcomes across the ICB areas. Stakeholders did think that there were some unique or particularly useful things done in each ICB area, as described in Table 4.

**Table 4: Stakeholder perceptions of unique or particularly positive elements in different ICB areas**

ICB area	Stakeholder perceptions of what worked particularly well
Bedfordshire, Luton and Milton Keynes	<ul style="list-style-type: none"> <li>Organised training programme on behalf of other ICBs</li> <li>There was high visibility of the role, with Leads embedded as part of the ICB's workforce leads team (alongside other clinical leads)</li> <li>A Lead is running monthly webinars for pharmacies and practices, which are well attended</li> <li>Successfully encouraged PCNs that were not part of the pilot to hire Leads with their own funds</li> </ul>
Cambridgeshire and Peterborough	<ul style="list-style-type: none"> <li>Had two Leads working together on many activities, almost like a job share. This provided capacity and peer support</li> <li>Leads developed a 3-6 month action plan with the ICB and tracked progress over time at regular meetings</li> <li>Involved Leads in Training Hub and ICB activities regularly</li> <li>Leads were part of the launch of the Integrated Neighbourhood Team, so pharmacy was represented from the outset</li> <li>Succeeded in encouraging a practice to do audits of Pharmacy First to provide information to pharmacies</li> </ul>
Hertfordshire and West Essex	<ul style="list-style-type: none"> <li>Tested 'big bang' approach, showing it is possible to implement Leads across all PCN areas simultaneously with high retention</li> <li>Training approach used pre-existing e-learning modules (along with other approaches), to test a sustainable/less resource intensive approach</li> <li>Had significant input from local pharmacy committee</li> <li>Monitored quantitative changes in referrals to pharmacy</li> <li>Secured sustained money for similar roles from core ICB funding</li> <li>Clear strategic vision to develop Leads as part of wider clinical leadership model within the ICB (including roles on Board)</li> </ul>
Mid and South Essex	<ul style="list-style-type: none"> <li>Training bespoke to the ICB area with lots of one-to-one sessions</li> <li>Set up WhatsApp group that includes PCN pharmacists as well as community pharmacists to get information directly from the PCN</li> <li>High levels of engagement with PCN/locality and alliance teams</li> <li>Significant input from local pharmacy committee</li> <li>Did event with Council to promote blood pressure readings in pharmacies</li> </ul>
Norfolk and Waveney	<ul style="list-style-type: none"> <li>Succeeded in helping a practice move to electronic prescribing</li> <li>Linked baseline data collection to other existing programmes</li> <li>Secured funding to continue roles for another year, and strengthened the remit to include more specific targets</li> <li>Leads reported ICB was very supportive of individuals throughout</li> </ul>
Suffolk and North East Essex	<ul style="list-style-type: none"> <li>Tested having a pharmacy technician in a Lead role</li> <li>Leads established a network to connect with each other. There were 5-6 leads so Leads were not isolated</li> <li>ICB representatives attended several training and support sessions, which provided a visible presence</li> <li>Basing decisions about next steps on evaluation findings, to make sure there is an evidence base</li> </ul>

Note: Based on interviews with stakeholders from ICBs, training hubs, local representative committees, community pharmacies, PCNs, general practices, Leads and training providers.

# Summary

Table 5 summarises the extent to which the pilot achieved its ambitions. We found that stakeholders in most PCN areas thought Integration Leads were helping to strengthen the profile and voice of community pharmacy, build relationships and champion collaboration.

The increases in stakeholder perceptions of communication and collaboration before and after the pilot are particularly striking when compared with the lack of change in PCN areas that did not have Integration Leads – especially since Leads only had about 14 days of time funded across the whole year, plus 6 additional days to take part in training.

During the pilot phase, the remit and processes of the role were left open so individual Leads did things in different ways and focused on different things. It is therefore perhaps not surprising that in some areas PCNs, practices and, to a lesser extent, pharmacies said that they had not heard from or actively engaged with their Integration Lead or felt that the Lead role was not empowered to support collaboration to meet their needs. These areas questioned the value of continuing roles like this.

It is too early to say whether the positive stories and activities described during the first year are generalisable and will translate into service transformation and better patient outcomes. Neither the East of England region as a whole or specific ICB areas had a greater increase in pharmacy referrals in the pilot period compared to [other NHS regions](#) in England. Integration Lead roles cannot be expected to do this alone, but may be an element of a wider strategy.

There is national funding expected to support roles like this in future for 2 days per month, as well as the potential to use existing funding sources. One ICB in this pilot has already allocated core funding to sustain Integration Lead roles and a PCN has used their core funding to hire their own Lead. This suggests that there is scope to refine and expand the roles to provide enough time to see whether they deliver a return on investment. Stakeholders generally felt that it was worth continuing to test Integration Lead roles, if processes and consistency were strengthened to maximise benefits. People suggested the following next steps:

- Setting **clear targets** for Leads to work towards. It is difficult to make the case for funding without evidence of change. An example might be increasing the number of Pharmacy First referrals (and linking this to financial indicators). There should be a process for continuing to monitor progress against any targets set.
- Strengthening the role description so that there are **consistent expectations** about activities that Leads will be responsible for (such as the degree of contact with individual practices).
- Considering having a Lead for each **Integrated Neighbourhood Team** / locality area rather than each PCN.
- Having a clear management and **accountability structure** so Leads and stakeholders have ways to escalate issues, and so there is a regular check on progress.
- Ensuring that enough capacity is set aside for ongoing **management** and support of Leads. Available funding tends to cover the Leads' time, not training or ongoing management. Stakeholders in this pilot suggested that it took time to organise and support Leads and that enough capacity needs to be ringfenced for this in future.
- **Promoting** the opportunity widely when recruiting new Leads. This might include using video snippets and stories from previous Leads and telephoning pharmacists directly to invite them to apply. Some areas may wish to try having pharmacy managers or pharmacy technicians in Lead roles, as well as pharmacists.
- Considering any ongoing development needs to ensure that Leads can progress into strategic or other roles. There may be potential to offer training or a community of practice on a regional scale. This could include using existing e-learning alongside quarterly peer support opportunities, plus one or two more formal training days per year explicitly linked to specific objectives of the role.

Table 5: Summary of extent to which the Integration Lead approach met year 1 ambitions

Ambition	Year 1 progress
<p><b>Learning</b> Learn whether Integration Lead roles are valuable and worth sustaining</p>	<ul style="list-style-type: none"> <li>• <b>Independent evaluation</b> compared stakeholder feedback before and after the test period, and tracked changes in referrals to pharmacies.</li> <li>• There was evidence that stakeholders who had direct and regular contact with Leads believed that relationships were being built, with some steps towards greater collaboration and joint problem solving. These 'close stakeholders' thought the roles had potential and were worth continuing. There were <b>measurable changes in before and after measures</b> of perceived communication, engagement and collaboration between pharmacies and PCNs.</li> <li>• Stakeholders that had less or no contact with Leads did not perceive benefits. They often felt strongly that the model was not worthwhile in its current form.</li> <li>• There was <b>wide variation</b> in how the Lead role was implemented in terms of what Leads focused on and how they worked. Some variation is appropriate to adapt to local needs, but the difference in scope and visibility of Leads influenced whether stakeholders saw the roles as useful.</li> <li>• Overall, three quarters of pharmacies, PCNs and practices in areas with Leads thought there was <b>potential value</b> from roles like this, as long as Leads worked towards specific targets and acted more consistently (perhaps with a 'menu' of activities that Leads are expected to do).</li> <li>• Many stakeholders felt that it would be more acceptable to have Integration Leads working across an <b>Integrated Neighbourhood Team</b> or locality footprint rather than the geography of a PCN. However Leads have limited time allocation. Some did not feel they had capacity to cover their PCN footprint well, let alone expanding to a wider remit. A lot was expected for 2 funded days per month.</li> </ul>
<p><b>Activities</b> Leads will focus on 7 key activities</p>	<ul style="list-style-type: none"> <li>• The Lead roles succeeded in focusing on <b>6 out of the 7 activity areas</b> described in the original proposal to test the model: <ul style="list-style-type: none"> <li>○ taking part in leadership training</li> <li>○ liaising with senior PCN roles</li> <li>○ embedding the community pharmacy voice within PCN meetings and structures (e.g. attending meetings; pharmacy being on agenda)</li> <li>○ linking with the local pharmacy representative committee and ICB about potential service developments (e.g. Pharmacy First)</li> <li>○ communicating PCN initiatives and priorities to local pharmacies and setting up mechanisms to engage with community pharmacies regularly (e.g. WhatsApp groups, group meetings), including neighbouring pharmacies outside the PCN footprint if relevant</li> <li>○ keeping records of activities and taking part in evaluation</li> </ul> </li> </ul> <p>The one area that Leads did not focus on was working with PCNs to develop rotational undergraduate and foundation pharmacy student placements. 2-3 Leads did some preliminary work relating to education and placements.</p>
<p><b>Outcome 1</b> Pharmacy teams will feel more engaged and know more about their PCN</p>	<ul style="list-style-type: none"> <li>• About one third more pharmacy representatives said they felt <b>more informed and engaged</b> than a year ago.</li> <li>• Pharmacies still thought there was more work to do to include pharmacies as PCN partners, but there were quantifiable increases in reported knowledge of the PCN and the extent to which pharmacies felt included.</li> <li>• In interviews, many pharmacy stakeholders attributed increased communication and engagement to the Integration Lead role</li> </ul>
<p><b>Outcome 2</b> PCNs and practices will know more about what community pharmacy can offer</p>	<ul style="list-style-type: none"> <li>• Some <b>practices and PCNs said they knew more</b> about what community pharmacy can offer compared to a year ago, and described how Leads influenced this. There were quantifiable increases in reported knowledge.</li> <li>• Pharmacies also thought that PCNs and practices knew more about what community pharmacy can offer.</li> <li>• This could be linked to the launch of Pharmacy First and other initiatives, not solely Integration Lead roles. However PCN areas with Leads reported knowing more about pharmacy activities and issues than areas without Leads.</li> </ul>
<p><b>Outcome 3</b> More collaborative working</p>	<ul style="list-style-type: none"> <li>• Some pharmacies, practices and PCNs said there is more joint working now. There were <b>quantifiable changes in areas with Leads, but not areas without Leads</b>.</li> <li>• Benefits were not universal. Some PCNs and practices had little contact with Leads, and they were least likely to think collaboration had improved.</li> </ul>