Community Pharmacy Somerset

Community Pharmacy Somerset Strategic Planning for 22-23

Our LPC Purpose
Lead, Promote, Connect.

- Michael Lennox
- CEO, Community Pharmacy Somerset (LPC)

22-23 Core Focus: Current Priorities + Pillars "Delivery Dozen"

6 Priorities

1. PCNs: Build relationships and involvement
2. Clinical Ops: Improved processes and patient care
3. GP-CPCS: Quantity with Quality (Q+Q) delivery
4. DMS: Get integrated Trust onboard and deliver Q+Q
5. Public Health Services: Reboot for growth
6. ICS-based service innovation: Expand for growth

6 Pillars

1. Be heard: Influence at ICS/PCNs/Agencies
2. Workforce and wellbeing: Recruit, Retrain, Retain
3. Drive Digital: Deploy ERD/SIDER, drive ops/care dividend
4. Representation Review: Implement outcome
5. Deliver for contractors: Move at scale and pace
6. Provide Return on Investment for system and contractors

Community Pharmacy Somerset

Celebrate and Build on Success (from 21/22 to 22/23)

People:

- Enhance PCN Lead Network with investment from system and now NHSEI Region
- Connect with coms to Contractors, Customers, Commissioners and Clinicians (ICS/PCN/Bulletin/Website)
- Look after ourselves and our contractors beyond Covid impact

Operate efficiently and effectively:

- Implement new ways of working for LPC eg Xero, new Executive, virtual working, new Coach roles
- Implement new services for system and contractors, eg GPCPCS, DMS, Hypertension (expanded), find the "One way/Best way" every time

Customer/Care

- Realise the promise of community pharmacy to be open door of care
- Build on base GPCPCS, Flu, Covid Vaccs, Hypertension, Hepatitis

Finance and Funding:

- Imagine and engineer business cases for community pharmacy investment
- Invest the funding allocations to optimise contractor return and to remain a resilient LPC delivery team

Opportunities: Function, Form and Funding

- Over-arching budget with reserves has never been richer
- We have been under pressure and face "new never busier" with ICS rise
- 22/23 is the "Year of the ICS" with the ambiguous complexity that will bring
- Core budget from levy is in positive reserve state and more funding is flowing (Digital Bid, Regional NHSEI PCN investment
- Project budget dedicated funds for each key area are full and ready to spend with CCG allowing us to expand core to core+, as well as have flexible project spend on integration, digital and clinical projects
- We have carried most of the expanded workload and resultant pressure in our core to date
- Agreed at late 21/22 Executive and Committee to seek solutions, expand core and find additional project delivery resource
- PCN Lead Coach and Clinical Support Coach roles signed off
- 22/23 will not see pressure ease, and Focus 5 is now Focus 12
- Representation Review dragging-on limits options to resource and creates funding uncertainty
- We cannot be seen to divert or take precious talent resource away from our contractors especially during the ongoing availably dip
- Impact of Representation Review unclear, evolution or revolution?

Current Priorities with Workload Coverage Recommendations

1. PCN Leads:

Who/How: Core, Core+ Peter as PCN Lead Coach with support from officers.

We have leveraged further funding support from NHSE Region for backfill and development programme. We still have CCG funds for primary care delivery including system engagement. There is scope to invest further should we need to eg rise of Neighbourhoods and Localities

2. Clinical Ops: Improved processes and patient care:

Who/How: Core, Core+ Fivos as Clinical Coach Yvonne as Ops Lead.

We are sensibly investing in dedicated resource as we move into deployment of next wave of national services and then optimisation of platforms and processes eg SIDER, Hypertension, Hepatitis

3. GP-CPCS: Quantity with Quality (Q+Q):

Who/How: Core, Core+ (to June)Yvonne and Michael continue as the system Implementation Team delivering from Phase 1 to 2 of plans, with view to it being a BAU/sustainable service at July. Subsequent enhancement cycles likely eg MAS/PGD expansion. New ICS based Com-Pharm Integration Lead starts.

Current Priorities with Workload Coverage Recommendations

4. DMS: Get integrated Trust onboard and deliver Q+Q

Who/How: Core, Core+, optimising the 1st phase approach adopted by YDH, and shepherding the same in the soon to be unified single trust will require a close cycle of project implementation. The Clinical Coach role will add to the contractor/pharmacist delivery

5. Public Health Services: Reboot for growth

Who/How: Core, Core+ if we develop beyond the basics, the rise of population health delivery in new ICS, will likely see us able to hardwire our offer in more effectively, so that more public health delivery is expected of us from our already in place services and more opportunity arises to do more eg Hepatitis screening and a much broader application of the Hypertension. There is risk to in an altering system state that we lose out if not there to influence.

6. ICS-based service innovation: Expand for growth

Who/How: Core, Core+, as per above we need to safeguard the existing and build beyond, the key factor is making the case for pharmacy to do more, and making the case to pharmacy to do ore

Current Pillars with Workload Coverage Recommendations

1. Be heard: Influence at ICS/PCNs/Agencies

Who/How: Core with likely Core+ needed as ICS new ways of working and touchpoints establish, along with Delegated Contract. Invest to get involved, influence and impact from first

2. Workforce and wellbeing: Recruit, Retrain, Retain

Who/How: Core+ Michael as System Lead, James as Com-Pharmacy Forum Lead, Anne as expert support for system and community pharmacy

3. Drive Digital: Deploy ERD/SIDER, drive ops/care dividend

Who/How: Core to Core+ with Clinical Coach, as move to make 22/23 the digital dividend year ie ERD and SIDER, use of new service platforms, P.Outcomes for all new services

Current Pillars with Workload Coverage Recommendations

4. Representation Review: Implement outcome

Who/How: Core, Executive leadership with full committee involvement.

We cannot concretely predict how the extensively the output of the RSG will impact us existentially.

The proposal and vote process could require us to cease, merge, or remain with a manifest change to our finances. Would any national direction, require local ratification? LPC is a sovereign body, and any change in an LPC requires local contractors and current committee approval and governance.

5. Deliver for contractors: Move at scale and pace

Who/How: Core, Core+ we design, deploy and deliver on all aspects of contractor need, whether reactively by process contract cycle eg PQS, PNA or proactive generation, eg emerging ICS Development, service innovation, bid engineering, we want to optimise contractor benefit.

6. Provide Return on Investment (system and contractors)

Who/How: Core, Core+?, as we move into ICS and rise of local autonomy, there will be more opportunity to leverage local to augment and enable national. That in turn will require more executive and operational effort.

ICS Integration: Achieving involvement, influence and impact

Principles in play:

We must remain flexible and agile, not box ourselves out by a rigid budgetary plan.

Do we need a contingency/risk register approach?

This is the biggest year ever, externally with rise of ICS, and internally with the Representation Review.

There is much "ambiguity and complexity and it takes time and effort to investigate

We must maximise and invest the funding allocations to optimise contractor return and to remain a resilient LPC delivery team

Key Stakeholders:

Determine the who, define the how and deploy executive grade resource

Goals:

Define at Committee our matching Delivery Dozens desired outcomes for the year