# Collaborative and Integrated Working between General Practice and Community Pharmacy:

## Findings from a Realist Review

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# Contents



Primary Care Sustainable Workforce
Supporting Equitable and Effective Patient Care

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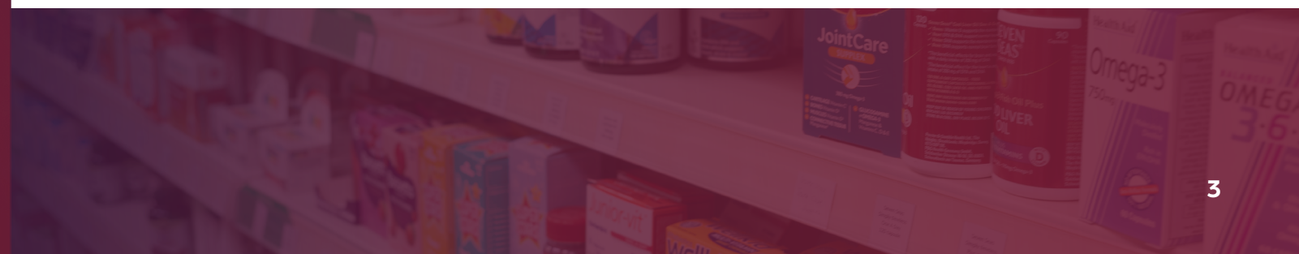


# Executive Summary


The National Health Service (NHS) Long-Term Plan marks a fundamental change in the nature and provision of UK primary care with, for example, General Practice (GP) and Community Pharmacy (CP) organisations encouraged to work towards more collaborative and integrated working. However, efforts can result in direct financial competition; reduced informational and relational continuity; and patient ambiguity about where to seek safe and appropriate help. We conducted a realist review, exploring how GP-CP collaborative and integrated working may work (or not), for whom, when, and why.

Key findings and recommendations from our review include:

1. **Avoid direct financial competition** between GPs and CPs: it undermines collaboration. Instead, set shared goals and reward jointworking.
2. **Establish a culture of trust and partnership**, building on shared values, so that individuals feel committed to work together. This requires clarity about regulation and ultimate/shared duties of care for patients.
3. **Develop professional and synergistic collaboration**. A variety of educational approaches can support collaborative and integrated working (e.g. regular informal dialogue, quality circles, and case conferencing). These can enable GPs and CPs to safely interact and learn with, from, and about each other.
4. **Use IT to support, rather than replace, GP-CP interactions**. GP and CP staff need formal and informal interactions to become (and remain) effective partners. Shared IT systems need to support, rather than replace opportunities for interaction.
5. **Some patients prefer private confidential spaces**, **while others like an informal, drop-in approach**. This can vary depending on the patient and/or their concern. Effective collaboration and integration can ensure patients have this flexibility where possible, but move between services where needed.
6. **Include patients**. Where patients see GP and CP staff collaborating effectively together and in their best interests, they are more likely and able to engage as an active partner in the process.


# Introduction

In recent years, UK healthcare services have expanded. Healthcare has become more distributed across different providers, professionals, and localities. Services can be in-person, on-line or both. In some circumstances, this has meant that patients experience a diverse and rich array of local services to support their healthcare. For others, care has become uncoordinated, fragmented, or inaccessible. Patient needs are often complex and multiple, particularly for patients who are elderly, or have co-existing challenges, e.g. low income, housing problems, relationship difficulties, unemployment, caring roles.

Healthcare needs are not a finite or fixed entity. Changes to healthcare systems often shift ways in which people are able to access services, perhaps reducing or increasing those able to seek help. So, although closer working between GP and CP might result in some reduction in workload for one or other organisation, there are a myriad of other intended and unintended consequences which can arise.

Some patients attend primary care (GP or CP) for help with a simple or pre-existing condition. However, a key primary care role for many patients is defining and prioritising the problem(s) with a healthcare professional, particularly for ambiguous, multiple or complex issues. This process enables cost-effective and focused primary care to be achieved in partnership with patients. When done well, this expertise enables healthcare professionals to share and discuss relevant issue(s) with patients; determine the nature of the problem(s) and possible relationship with pre-existing illness or medication; explore potential underlying triggers; recognise what is known and not known at this stage; and plan next steps. Going forward, GP and CP working needs to enable this key primary care role to flourish, to ensure effective, timely and equitable patient care.

# What We Did

This report was produced following a rigorous and in-depth literature review(1). The team included pharmacists, doctors, nurses, patients, carers, and academics. We consulted with key stakeholders at regular points in the research. The review sought to explore how, why, and when collaboration and integration between GP and CP worked (or not) to enable equitable and effective patient care.

Collectively, a total of 136 documents were included in the final synthesis. Documents were published between 2000 and 2021, and included 124 published research articles, 4 conference abstracts, and 8 others (e.g., policy reports and guidance articles). Throughout the review process, we engaged in regular collaborative discussions with our four patient co-applicants encompassing both family and carer perspectives, and eight stakeholder members, reaching across GP and a range of CP providers (small, medium, and large), including policy and practitioner perspectives.

> ***It's been hard work, especially at the start, but it gave me an incredible buzz, playing a complementary role to the doctors and the practice nurses and I would really like to do more of this type of work.***
>
> community pharmacist (6)

> ***...What my doctor says to me... If the pharmacist confirms it, then I'm very happy.***
>
> patient (6)

Through reflective dialogue, our patient co-applicants and stakeholder members informed the selection of texts and interpretation of data. This process helped our team to see problems from new angles; focus our analysis; and maximise the relevance of our results and recommendations for policy, practice, and patient care. For example, our patient co-applicants and stakeholders informed possible ways of thinking about patient care in relation to access, help-seeking behaviour, therapeutic relationships, and continuity. Also, the role of the patient as both a 'user' and a 'broker', as they play a mediating and managing role, moving back and forth between GP and CP.

# Summary of Review Findings

This document shares evidence-based recommendations based on our review findings, to support collaborative and integrated working within your setting: working with, and for patients across organisations and healthcare professional groups. The evidence suggests that **one size does not fit all**. But there are important key areas outlined below, which you and your organisation can consider or facilitate, to maximise opportunities for collaboration and integration to enhance equitable and effective patient care.

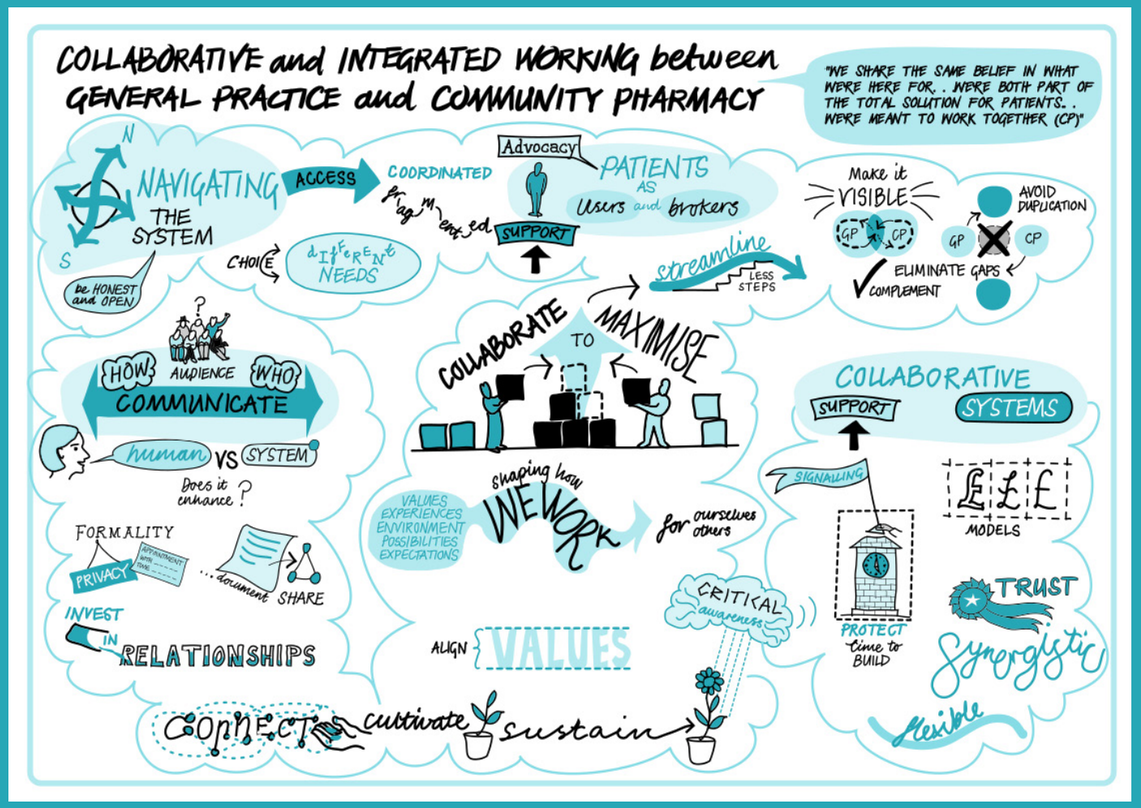
Working together is important but can be challenging. Healthcare systems are increasingly complex and, in the UK, include an array of NHS and private services. Sometimes services are competing for funding or patient numbers. In other situations, services are connected and coordinated.

> ***Sometimes fortunately [community pharmacists will] let you know if maybe there is an interaction that you might not have been aware of... I mean, that's like finding gold or something when that happens.***
>
> general practitioner (6)

While patients expect confidentiality, many assume information told to one healthcare professional will be shared with another. Challenges to effective exchange and collaboration include ad hoc or fragmented care. Possibilities for connection between GP and CP staff are dependent upon policy priorities. Nevertheless, this review shows how collaboration and integration can be achieved, or maximised, where opportunities arise.

> ***We [community pharmacists and general practitioners] share the same belief in what we're here for... we're both part of the total solution for patients... we're meant to work together.***
>
> community pharmacist (8)

**This infographic highlights key issues described in this report about collaborative and integrated working between General Practices (GP) and Community Pharmacies (CP) identified within our analysis. These include enablers as well as challenges and ways to mitigate for these.**




## Key factors identified in our review include:

### Navigating the system

Sometimes patients struggle to access or coordinate care across health professionals and organisations. Patient engagement with different services is sometimes positioned as a 'choice' or 'preference'. A service, for example, might be provided in more than one setting or by multiple professionals, albeit with some differences (e.g. public versus private space, focus of interaction, possibilities for future continuity). Most services and professionals, however, meet different patient needs. In some contexts, these are coordinated and connected, in others they are fragment or disjointed. This is not always apparent to patients, who often assume communication and coordination of care is established across healthcare professionals and organisations.

Patients often need support and advocacy from healthcare professionals, to maximise opportunities for partnership in their care. Being honest and open about how systems work, in addition to focused conversations about diseases and health conditions, is important to support patient involvement and brokering of collaboration and integration.

**Patient trust in healthcare professionals shared care:**

> ***"I'm going to let the doctor, [whom] we've chosen and trusted, help guide us in those decisions. If she says my children should get the vaccine and [that] it doesn't matter if they get it at her office or the pharmacy... [then] I trust her."***
>
> patient (11)

### Communication

It is important to consider how and who communicates across patient encounters with professionals and services. Where communication and coordination do exist, this might be facilitated in a range of ways. Facilitators include personal connections (e.g. informal, formal, direct, and indirect) or more system-led approaches (e.g. distribution of written material to another organisation summarising an encounter, which then needs to be read, stored, and potentially acted upon by another). Communication approaches can enhance opportunities for future collaboration (e.g. relationship-building and shared learning) or minimise this (e.g. creating multiple documents to review, code or file each day, impacting on time available for human interactions).

### Connecting

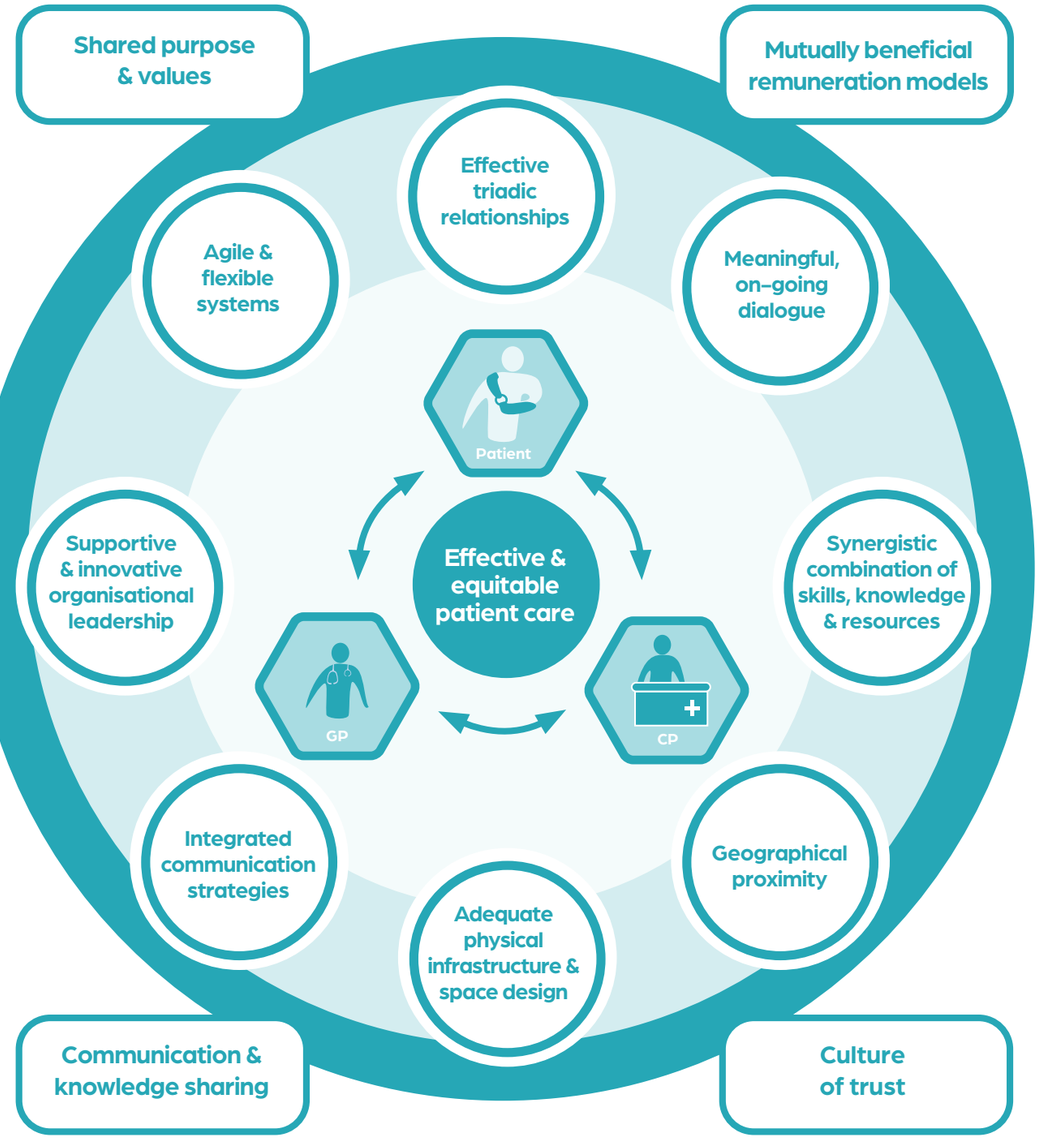
Connections between individuals and organisations do not happen without dedication, commitment, and intention (2). These can happen in a myriad of ways, but consideration needs to be given to how connections are fostered and maintained over time. Some connections might happen through formal meetings, e.g. multi-disciplinary agency meetings, case conferencing, or quality circles. Others might be more developmental in nature, e.g. informal coffee and regular lunchtime discussions. These spaces needs to be cultivated and sustained to enable individuals to connect and learn about other services, colleagues, and patient experiences. This requires organisational and financial support to flourish.



# Collaboration and Integration

## Programme theory

In realist reviews or evaluations, a programme theory is created during the analysis to explain an intervention or process. Below, our programme theory explores for whom, when and how collaborative and integrated working between GP and CP enables effective and equitable patient care.



**Mutual and transformative learning opportunities:**

> *In fact, he [community pharmacist] picked up a couple of people who unfortunately had impotence with their drug therapy and **we didn't know** – he by the way gave them very good advice. We changed one person's medication, and we referred one for special counselling and treatment.*

general practioner (7)

**Supportive and innovative organisational leadership:**

> *... [management] really support us doing these things... these new services. [Manager] helps us find help to get started and points us in the right direction with how to track and record.*

community pharmacist (11)

**Trusting professional relationships (pre–existing or evolving):**

> *I've got a good relationship with the pharmacists that work around my area, notwithstanding that sometimes they have a pharmacy... a different pharmacist come[s] in and help[s] them out, but the ones that are there regularly **I know quite well** and I'm quite happy to pick up the phone and talk to them about patients' prescriptions and sometimes I will ring them and check to see if they've actually been dispensed as the patient says or tells me, just to **double check**.*

general practioner (9)

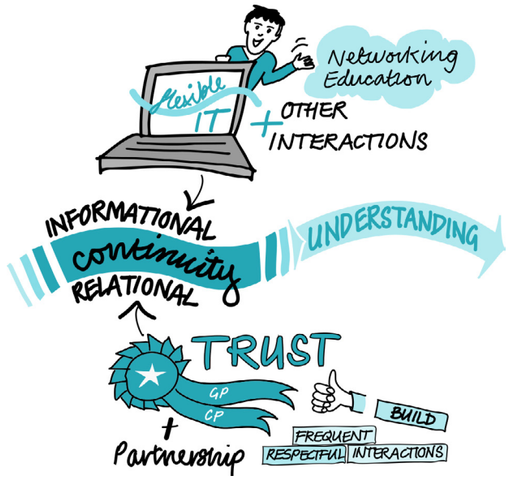

# Putting the Evidence into Practice

How can I use the findings from this review?

In the next section, we present a series of questions to help you implement our review findings. There is no one right approach or answer. It is, however, important that each professional is aware of how and to what extent their own working practices overlap and intersect with others within the system, and how this impacts patient care.

> *There was a lot of phone communication, but travelling both ways, him querying scripts and us asking for advice. I would often pop into the shop and have a chat with him. I suppose I would see him, talk to him, two or three times a week.*

general practitioner (10)




This can also support ways in which this working might be achieved (e.g. direct interaction, IT system changes, physical infrastructure modifications, patient narratives of service experiences, financial remuneration models etc.). Our attitudes and approaches to collaboration and integration are shaped by our past experiences, our values (what matters to us), our current working environment and related possibilities, and expectations about the future. These are all likely to inform how we might deliver or organise patient care, and in turn, possibilities for shaping ways of working together with patients and across individuals, teams, and organisations.

## 1. Communicating with others

**Are spaces for patient conversations public or private?** How do spaces limit or enable opportunities for patient access, or the types of problems they might share or bring?

**How are your conversations with patients documented and/or shared with other healthcare professionals or organisations?** When (with permission) would this be helpful? How? Direct (e.g. verbal face-to-face, phone, email, IT system) or indirect (e.g. via a patient)? What are the pros and cons of each?

**How might communication or documentation depend on the intended audience** (e.g. the professional group, organisation, and patient) and why? We often assume that patient information is fixed. However, stories and priorities can change over time and place. What are your priorities when listening to patients and how do you record these? How might this differ to a patient conversation elsewhere?

**How do you invest in your relationships with others to maximise effective communication** (e.g. building trust or maintaining working relationships) to enhance, rather than obstruct opportunities for human connection?

## 2. Supporting collaborative systems

*Making money work to support collaboration and integration*

**Do payment models for work and care enable opportunities for collaboration** (e.g. ways to complement income, expertise, clinical autonomy, or dedicated learning systems)?

**Is there protected or explicit time to build and consolidate relationships with others**, increase awareness of how others work, care, and interact with each other, you, and patients?

*Maximising capacity*

**How can your organisation enhance capacity through collaboration** (e.g. efficient and meaningful communication, minimising steps to support patient care across services, working in partnership with patients), rather than creating additional tasks, or competing with limited time?

**How do (or could) your IT systems avoid duplication of work, eliminate gaps, or enhance collaboration opportunities?** Are they agile/flexible to meet needs of different healthcare professional groups and patient priorities?

*Learning and growing across systems*

**How do people in your organisation and across local organisations learn about what each other does** to support patient care (e.g. informal conversations, shared learning events, co-location)?

**How does your organisation implicitly or explicitly indicate** to staff that collaborative and integrated working is important to patient care and a valuable activity? What might undermine this?

**How do you promote trust and cooperation** across healthcare professionals and organisations?

**How can you work in more synergistic ways** to meet patient needs through working with others (people and organisations) to maximise cross-disciplinary working and joint service initiatives?

**Are your systems agile and flexible enough** to enable staff to adapt to each other's and patients' needs, as well as supporting iterative growth and learning?

## 3. Patients as users and brokers

Collaboration and integration enables professionals to advocate for patients and support their engagement across services. It can also maximise opportunities for patients to be active partners in their care and personalise the support they receive.

**How can you support patients to engage with services across healthcare professionals and organisations** (e.g. evidence of shared working and knowledge of local services and people; maximising trust through evidence of effective collaborative working relationships; seeking patient permission to share relevant information)?

**How and when can patients' broker across services and local colleagues to streamline and enhance their experience of care?** How and when does this need to be supported to ensure equitable care to meet patient needs?

**How does your service meet patient needs** in relation to others, and how do these overlap, compete or complement each other (e.g. continuity with professionals, access, informal/formal spaces, booked, impromptu, language/cultural familiarity)?

**How is cross-working across healthcare professionals and organisations made visible to your patients?** Are patients with you when you pick up the phone to clarify something? Can you advise patients how to access help elsewhere? Do you know colleagues by name?

**How and when do patients feel comfortable attending your service alongside others?** When might patients have concerns about loyalty, overlap, competition, or conflicting priorities? How can you assess and/or address these (e.g. how to establish and enable trust about others' capability, or gauge their aligned/different values and focus regarding your patients' 'best interests')?




# In Conclusion

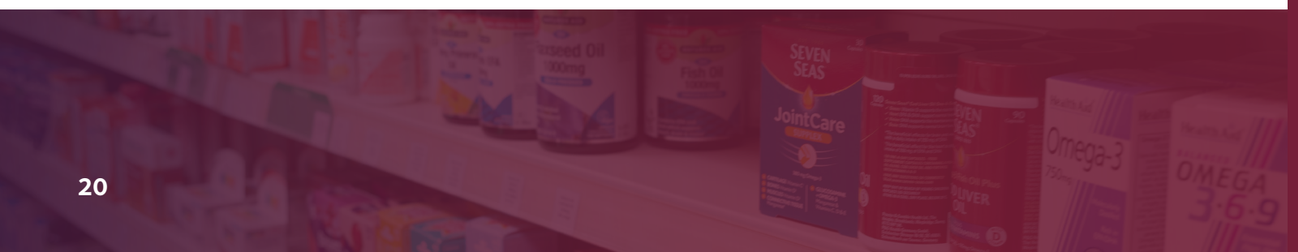
Sometimes collaboration and/or integration is not possible or appropriate. Often, however, collaboration and integration have the potential to enhance the quality and equity of patient care (2–5).
In order to get started, some clear questions need to be asked from the outset:

- Do the values of this individual or organisation align enough with my own; that we can trust each other and work together to support or prioritise patient care?
- Next, do changes need to be made to funding or financial remuneration models to ensure that collaboration and/or integration of services is possible and beneficial to both parties?

> ***"I didn't know the general practitioners before I started the study [five-month feasibility study], but I soon got to know them and once I had suggested a few drug changes, not just the anginal drugs but others as well, they started to ask my advice, as did the other practice staff."***
>
> community pharmacist (7)

Once these core factors are established, then you can move onto key considerations including:

- Embedding regular informal and formal dialogue and education opportunities to nurture trusting, professional collaboration.
- Ensuring IT systems support rather than replace human interactions (with patients and colleagues) and provide agility and flexibility to adapt to local patient, provider, and community needs.
- Acknowledge the impact of space when services are distributed across GP and CP: shaping how, when and for what, different patients might attend GP or CP with particular needs (e.g. public or private, ad hoc or pre-booked, familiar or anonymous staff).
- Patient advocacy and support to engage and/or move between GP-CP to ensure safe, effective and equitable care. Where GP-CP collaboration and integration is explicit to patients, and trusting relationships visible, patients are more able to engage as an active partner in this process.



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