PSNC response to Integrating care - Next steps to building strong and effective integrated care systems across England

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Introduction

The Pharmaceutical Services Negotiating Committee (PSNC) promotes and supports the interests of all NHS community pharmacies in England. We are recognised by the Secretary of State for Health and Social Care as the body that represents NHS pharmacy contractors. We work closely with Local Pharmaceutical Committees (LPCs) to support their role as the local NHS representative organisations.

Our goal is to develop the NHS community pharmacy service, and to enable community pharmacies to offer an increased range of high quality and fully funded services; services that meet the needs of local communities, provide good value for the NHS and deliver excellent health outcomes for patients.

We welcome the opportunity to be able to provide our response to the proposals set out in NHS England's consultation document *Integrating care - Next steps to building strong and effective integrated care systems across England*.

Response

We provide our response to the specific questions posed in the document below although we have some apprehension that such far reaching proposals have been brought forward at the current time, during the Christmas and New Year period, and during a pandemic and a surge in cases; even though these proposals build on previous work and final decisions will be made in due course and many are subject to Parliament. It is questionable whether all those organisations and individuals who might want to respond and engage are in a position to do so.

Consultation questions

1. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

We agree with the need for greater collaboration between partners in healthcare and that ICS have the potential to offer stronger partnerships and local commissioning and use digital and data to drive locally led system working, to improve patient outcomes.

We agree with the four fundamental purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development.

What is not clear in the consultation is how the proposed new NHS systems will ensure these purposes continue to be realised, or realised to a greater extent, in primary care.

We suggest that there will need to be further discussions and greater clarity on the role of ICS as potential commissioners of primary care services to ensure that the current services, future planned services and the increasing role of community pharmacy in the provision of services are maintained and maximised, to the benefit of patients, the public and the NHS.

From the consultation document, it is unclear what NHS England and NHS Improvement (NHSE&I) are proposing in relation to primary care commissioning and how this may affect the commissioning of community pharmacy services, including how the sector can maximise its impact on reducing health inequalities within the population.

2. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

Yes, we agree that option 2 provides a clearer model for local leadership of NHS services and it would be preferable to the alternative. We do not consider that CCGs being retained alongside ICS on a statutory footing would provide clarity of decision-making and governance.

The proposed option 2 model being acceptable is on the basis that :

- the concerns identified in the answers to the other consultation questions are addressed satisfactorily; and
- the principle of patient choice which applies to NHS services, including genuine choice of which pharmacy to use, without any system incentive, is maintained.

3. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

No.

While we understand the desire for local flexibility in ICS membership and governance, historic experiences of the governance of previous local NHS bodies illustrates that primary care providers, beyond general practice, struggle to have their voice heard in an unstructured governance framework. This is because larger providers, such as NHS Trusts and to some degree general practices, have a dominant voice.

We have a general concern that in the evolution of the role of ICS, there is a significant risk of the needs of large NHS Trusts driving ICS agendas.

We note that within the consultation, there is recognition that 'provider organisations will play an **active and strong leadership role** in systems.' Also, that where there is already strong and effective place-based partnerships, one of the common characteristics is 'a leading role for clinical primary care leaders through primary care networks.'

As such, we recommend that it is directed that all primary care providers must be part of the governance of ICS, with Local Pharmaceutical Committees (LPCs) being the appropriate organisations to represent community pharmacy within the governance structure.

LPCs are already involved in supporting the implementation of national community pharmacy services, supporting Primary Care Network community pharmacy leads and helping to coordinate local services delivered through the community pharmacy network.

We consider it is essential to have adequate and appropriate representation from the primary care sector and, in particular, from community pharmacy.

4. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

The body of the document refers to primary care functions undertaken by CCGs potentially being moved to ICS operating on a statutory footing. This could therefore be interpreted as referring only to the co-commissioning of general medical services.

The document also refers to treating CCG staff appropriately, should their employment need to be moved to a new NHS body, but there is no similar reference to primary care commissioning staff in NHSE&I regional teams.

At the same time, the document refers to 'increasingly organising the finances of the NHS at ICS level and putting allocative decisions in the hands of local leaders'; as well 'creating a single pot, which brings together CCG commissioning budgets, primary care budgets… and nationally held transformation funding that is allocated to systems.'

We are therefore unclear as to what proposal NHSE&I is making in relation to primary care commissioning, including whether it is proposed that ICS hold the Pharmaceutical List in the future.

If NHSE&I are proposing that all four primary care contracts are moved to ICS, that would be a very significant change which would require detailed consideration of the benefits and risks, alongside mitigations for any identified risks.

The legislative framework for community pharmacy and the significant financial savings for the Government and the public pursue obtained through the competitive purchasing of generic medicines for NHS supply would also need to be considered.

PSNC would expect to be fully involved in such discussions in relation to the NHS Community Pharmacy Contractual Framework.

Important to community pharmacy is the principle of national funding for pharmacy contractors to ensure consistent delivery of service and a fair share of available funding for each contractor in each area (commensurate with services provided) for the benefit of patients.

There is also a risk of loss of capacity, knowledge and skills of existing primary care commissioners within NHSE&I where roles are transferred. As an example, the NHS re-organisation of primary care support in England resulted in the loss of some skilled individuals within NHS organisations, to the detriment of the efficient running of systems and ultimately, patients; as well as significant issues for primary care contractors.

Therefore, we cannot provide a clear response to question four at this time, due to the lack of clarity in relation to the breadth of the primary care commissioning proposals within the document. We ask NHSE&I to provide greater clarity on their thinking regarding any potential transfer of the commissioning of community pharmacy and other primary care services to ICS, followed by appropriate engagement with PSNC and other representatives of NHS primary care contractors, if this is relevant.

We can see the benefit of primary care commissioning being undertaken by one local body, alongside other local NHS commissioning and planning, so the value of primary care services can be maximised for the benefit of patients and taxpayers, but there would also be potential risks, including the governance challenges that we refer to in our response to question three.