The Healthcare Landscape

July 2021

PSNC Briefing 019/21: Summary of the Integration and Innovation DHSC White Paper and associated guidance documents

On 11th February 2021, the Government published a White Paper – Integration and Innovation: working together to improve health and social care for all – setting out proposals for primary legislation which would make changes to the structure of the NHS in England.

An associated NHS England and NHS Improvement (NHSE&I) document - Legislating for Integrated Care Systems: five recommendations to Government and Parliament – was published alongside the White Paper and on 16th June 2021, NHSE&I published the first version of its Integrated Care Systems: design framework.

This document is an updated version of PSNC Briefing 006/21 which summarises the key points that are of relevance to community pharmacy in all three of the above publications and highlights the potential implications for the sector.

Introduction and background

Most of the changes proposed in the White Paper are aligned with the NHSE&I proposals for legislative change, on which they consulted in late 2020. Their proposals described the legislative changes the NHS needed to help it to deliver the improved outcomes set out in the NHS Long Term Plan.

Read the NHSE&I consultation document or the PSNC summary of the document

Read the PSNC response to the NHSE&I consultation

The NHSE&I proposals were the culmination of a journey which has developed policy on the better coordination of health and care:

2014	NHS and Local Government's national leaders set out a vision of more collaboration in the NHS *Five Year Forward View*.
2015	'Vanguards' in 50 areas began to develop and test new models of care.
2016	The NHS and local councils formed Sustainability and Transformation Partnerships covering all of England, to consider local health and care priorities and to plan services together.
2017	Areas refined initial proposals, drawing on conversations with frontline staff, local residents and others in the community.
2018	Some partnerships began to take on more responsibility by becoming 'integrated care systems'.
2019	The NHS Long-Term Plan confirmed that every area will be served by an integrated care system by 2021, with primary and community services funded to do more.
2020	Building on previous publications for legislative reform, NHSE&I set out details for how systems will accelerate collaborative ways of working in the future, considering the key components of an effective integrated care system and reflecting what local leaders have said about their

	experiences during the last two years, including the immediate and long-term challenges presented by the COVID-19 pandemic.
2021	NHSE&I response to the Integrated Care System consultation document and the Government brings forward legislative proposals to support integration. Initial version of a design framework for ICS published by NHSE&I.

The NHSE&I proposals were designed around three principles: any legislation should solve practical problems; avoid a disruptive top-down reorganisation; and have broad consensus within the system. The stated aim of the measures outlined in the White Paper is to make it easier for NHS organisations and their partners to work together to tackle the issues that matter most to the people they serve.

The new legislation is planned to be introduced in 2021, with the new NHS structures commencing on 1st April 2022, but that is subject to parliamentary process.

The legislative proposals

While most of the Government's proposals directly implement NHSE&I's recommendations, they have also been augmented where the experience of COVID-19 suggests there is a case to go further to reach their objectives. These additional proposals relate to public health, social care, quality and safety matters.

Working together and supporting integration

The Government propose to legislate to support integration, both within the health service, and between the health service and local government. This will involve legislation so that **every part of England will be covered by an integrated care system (ICS)**.

Statutory ICS will be created, made up of an **ICS NHS Body** and an **ICS Partnership** (together referred to as the ICS), to strengthen the decision-making authority of the system leadership and to embed accountability for system performance into the NHS accountability structure.

This dual structure recognises that there are two forms of integration which will be underpinned by the legislation:

i. the integration within the NHS to remove some of the barriers to collaboration and to make working together across the NHS an organising principle; and
ii. the integration between the NHS and others, principally local authorities, to deliver improved outcomes to health and wellbeing for local people.

The ICS NHS Body

The ICS NHS Body will **take on the commissioning functions** of the Clinical Commissioning Groups (CCG) and some of those of NHSE&I within its boundaries, as well as CCG's responsibilities in relation to Oversight and Scrutiny Committees. It will not have the power to direct NHS Trusts.

The ICS NHS Body will be responsible for:

- **Developing a plan** to meet the health needs of the population within their defined geography;
- **Allocating resources** to deliver the plan across the system, including determining what resources should be available to meet the needs of the population in each place and setting principles for how they should be allocated across services and providers (both revenue and capital);
- **Establishing joint working arrangements** with partners that embed collaboration as the basis for delivery of joint priorities within the plan. The ICS NHS body may choose to commission jointly with local authorities, including the use of powers to make partnership arrangements;
- **Establishing governance arrangements** to support collective accountability between partner organisations for whole-system delivery and performance; and
- **Securing the provision of health services** to meet the needs of the system's population.

The ICS NHS Body will also be able **to delegate to place level and to collaboratives of providers**[1].

Each ICS NHS body will have **a unitary board**, and this will be directly accountable for NHS spend and performance within the system. The board is expected to include a chair, another two independent non-executive directors, the CEO, director of finance, director of nursing, medical director, representatives from NHS Trusts, general practice, local authorities and others determined locally. ICS will also need to ensure they have appropriate clinical advice when making decisions.

NHSE&I through its regional teams, will agree the constitutions and plans of ICS NHS bodies and hold them to account for delivery through the chair and chief executive.

The ICS Partnership

An ICS Partnership, jointly convened by local authorities and the NHS, **made up of a wider group of organisations** than the ICS NHS Body, will bring together health, social care, public health and potentially representatives from the wider public space where appropriate, such as social care providers or housing providers.

The White Papers says members of the ICS Partnership could be drawn from several sources including Health and Wellbeing Boards (HWB) within the system, partner organisations with an interest in health and care (including Healthwatch, voluntary and independent sector partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers). The Government's intention is to specify that an ICS should set up a Partnership and invite participants, but they do not intend to specify membership or detail functions for the ICS Partnership, allowing systems to appoint members and delegate functions to it, as they think appropriate.

The NHSE&I document (Legislating for Integrated Care Systems: five recommendations to Government and Parliament), published at the same time as the White Paper states:

> *NHSE&I expect primary care to play a key leadership role in the future of ICS, with a central role in providing joined up care at neighbourhood and place level. There will also be an important role for primary care professionals in place-level committees, working with partners to integrate services for their patients. Clinical, and wider multi-professional, involvement will be central to success at system and place level.*
>
> *There are various possible options including professional representation in place-based committees. We will work with professional groups and emerging ICS over the next few months to develop guidance on professional involvement. In approving the establishment of statutory ICS, NHSE&I will expect to see proposals for professional involvement which have been developed locally with those professionals.*

The ICS Partnership will be responsible for developing an **integrated care strategy** that addresses the wider health, public health and social care needs of the system. NHSE&I say it should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments. The plans are expected to be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the COVID-19 pandemic for communities.

The ICS NHS Body and Local Authorities will have to have regard to the integrated care strategy when making decisions.

The ICS will also have to work closely with local HWBs and the ICS NHS Body will be required to have regard to their Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies. The White Paper also notes that **ICS will also want to consider how they can align their financial allocation functions with place level**, for example through joint committees, though the Government are leaving this to local determination.

[1] Provider collaboratives are partnership arrangements involving two or more trusts (foundation trusts or NHS trusts) working across multiple places to realise the benefits of mutual aid and working at scale.

To facilitate broad membership and stakeholder participation, NHSE&I says ICS Partnerships may use a range of sub-groups, networks and other methods to convene parties to agree and deliver the priorities set out in their shared strategy. They also note that as a key forum for convening and influencing and engaging the public, the ICS Partnership will need to be transparent with formal sessions held in public. Its work must be communicated to stakeholders in clear and inclusive language.

NHS Trusts and Foundation Trusts will remain separate statutory bodies with their functions and duties broadly as they are in the current legislation.

Place-based Partnership

Partnerships between organisations to collectively plan, deliver and monitor services within a locally defined 'place' have a long history. These place-based partnerships, which have typically been established by local agreement, are now expected to be consistently recognised as a key player in the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health.

NHSE&I has asked each ICS to define its place-based partnership arrangements, covering all parts of its geography, agreed collaboratively between the NHS, local government and other system partners working together in a particular locality or community.

NHSE&I's design framework states:

> *The ICS NHS body will want to agree with local partners the membership and form of governance that place-based partnerships adopt, building on or complementing existing local configurations and arrangements such as Health and Wellbeing Boards.*
>
> *At a minimum, these partnerships should involve primary care provider leadership, local authorities, including directors of public health, providers of acute, community and mental health services and representatives of people who access care and support.*

Primary care within ICS

ICS will be accountable for outcomes of the health of the population and this will be supported by a broad **duty to collaborate** across the health and care system and a **triple aim duty** on health bodies, requiring them to ensure they pursue simultaneously the three aims of:

1. better health and wellbeing for everyone;
2. better quality of health services for all individuals; and
3. sustainable use of NHS resources.

NHSE&I's design framework states:

> *All primary care professionals have a fundamental role to play in ensuring that ICS achieve their objectives. The success of efforts to integrate care will depend on primary care and other local leaders working together to deliver change across health and care systems.*
>
> *Primary care should be represented and involved in decision-making at all levels of the ICS, including strategic decision-making forums at place and system level. It should be recognised that there is no single voice for primary care in the health and care system, and so ICS should explore different and flexible ways for seeking primary care professional involvement in decision-making. In particular, primary care should have an important role in the development of shared plans at place and system, ensuring they represent the needs of their local populations at the neighbourhood level of the ICS, including with regards to health inequalities and inequality in access to services.*

ICS should explore approaches that enable plans to be built up from population needs at neighbourhood and place level, ensuring primary care professionals are involved throughout this process

Primary Care Networks (PCN)

PCNs can be seen as forming the 'smallest building block' of the wider ICS structure. NHSE&I's design framework states:

PCNs in a place will want to consider how they could work together to drive improvement through peer support, lead on one another's behalf on place-based service transformation programmes and represent primary care in the place-based partnership. This work is in addition to their core function and will need to be resourced by the place-based partnership.

ICSs and place-based partnerships should also consider the support PCN clinical directors, as well as the wider primary care profession, may need to develop primary care and play their role in transforming community-based services.

Primary care commissioning

The White Paper references an NHSE&I proposal that medical, dental, optical and pharmaceutical services should be commissioned by ICS and this is further reiterated in NHSE&I's document **Legislating for Integrated Care Systems: five recommendations to Government and Parliament**, in which recommendation 5 is:

> **Legislative recommendation 5**
>
> Provisions should enable the transfer of appropriate primary medical, dental, ophthalmology and pharmaceutical services by NHS England to the NHS ICS body. Provision should also enable the transfer or delegation by NHS England of appropriate specialised and public health services we currently commission. And at the same time, NHS England should also retain the ability to specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.

In the document, NHSE&I reaffirm their **continued commitment to national contractual arrangements across the primary care contractor professions**.

The NHSE&I document also notes that they will undertake **a comprehensive primary care commissioning transformation programme**, working with contractors, clinicians, NHSE&I's own regional commissioners, ICS and others to ensure the safe and effective transfer of any primary care commissioning functions to ICS bodies. At the same time, they will maintain a national role in agreeing and maintaining contracts, and managing back office functions and performers lists.

It goes on to say, for all services (regardless of who the commissioner is), NHSE&I will continue to have a role in setting national standards and service specifications, and maintaining nationally mandated contracts to ensure continuing national consistency, alongside any other appropriate safeguards NHSE&I and stakeholders identify as essential to preserving the safe and effective commissioning of these services (e.g. an appropriate assurance and oversight framework). Additionally, there can be a phased approach to the implementation of any future operating model to ensure the safe transfer of service commissioning, once safeguards are in place, financial flows and resources are clear, and all systems are fully prepared for any new responsibility.

NHSE&I has subsequently stated, in its design framework document:

The legislation will enable the direct commissioning functions of NHS England and NHS Improvement to be jointly commissioned, delegated or transferred at an appropriate time to ICS NHS bodies.

NHS England and NHS Improvement is considering how it might shift some of its direct commissioning functions to ICS NHS bodies. Subject to discussions with systems and our Regions and further work on HR, our intention is to enable ICS NHS bodies to take on responsibility as soon as they are ready to do so after the enactment of legislation.

Commissioning of primary medical services is currently delegated to CCGs and will transition immediately into ICS NHS bodies when they are established. ICS NHS bodies might also take on primary dental services, general ophthalmic and pharmaceutical services commissioning.

Reducing bureaucracy

The Government will use legislation to ensure the NHS is **free to make decisions on how it organises itself, without the involvement of the Competition and Markets Authority**.

They will also **reform how health care services are arranged by creating a bespoke health services provider selection regime** that will give commissioners greater flexibility in how they arrange services than at present. NHSE&I recently consulted on this topic.

The Government will also give commissioners more discretion over when to use procurement processes to arrange services than at present, with proportionate checks and balances. This will be undertaken by removing the current procurement rules which apply to NHS and public health commissioners when arranging healthcare services.

These reforms will only apply to the arrangement of healthcare services – including public health services whether commissioned solely by a local authority or jointly by the local authority and NHS as part of a Section 75 agreement. The procurement of non-clinical services, such as professional services or clinical consumables, will remain subject to Cabinet Office public procurement rules.

The White Paper says where competitive processes can add value, they should continue, but that will be a decision that the NHS will be able to make for itself. These changes retain a division of responsibility between strategic planning and funding decisions, and care delivery.

The Government also propose the **removal of Local Education Training Boards (LETB) from statute**. LETB were originally established in 2012 as statutory sub-committees of Health Education England (HEE) to perform its functions at local and regional level. Removing LETB from statute with their functions continuing to be undertaken by HEE (and reporting to the HEE Board) will provide HEE with the flexibility to adapt its regional operating model over time.

Additionally, the Government will make a statutory duty for the Secretary of State for Health and Social Care to publish document, once every five years, which sets out roles and responsibilities for workforce planning and supply in England.

Enhancing public confidence and accountability

The evolution of the system in recent years has led to a greater level of responsibility being held by NHSE&I; as ICS are established, the Government expect more of that responsibility to be held by them.

The current set of national NHS bodies has already altered in form and purpose, and in the proposed legislation, the Government intend to **formally bring together NHS England and NHS Improvement into a single legal organisation**.

They also plan to **bring forward a complementary proposal to ensure the Secretary of State for Health and Social Care has appropriate intervention powers** with respect to relevant functions of NHS England. This will support the Secretary of State, when appropriate, to make structured interventions to set clear direction, support system accountability and agility, and also enable the Government to support NHS England to align its work effectively with wider priorities for health and social care.

This will be accompanied by measures to strengthen and clarify the role of Government and Parliament. The Department will also have a critical role to play in overseeing the health and care system and in ensuring strong alignment and close working between public health, healthcare and social care.

There will also be a **more flexible mandate for NHS England,** which will make it easier for the Secretary of State to set objectives for the body.

Public health

Measures will be brought forward to make it easier for the Secretary of State to direct NHS England to **take on specific public health functions**; help **tackle obesity by introducing further restrictions on the advertising of high fat, salt and sugar foods;** as well as a new power for Ministers to alter certain **food labelling requirements**.

The White Paper notes that our collective experience of the pandemic underlines the importance of a population health approach: preventing disease, protecting people from threats to health, and supporting individuals and communities to improve their health and resilience.

The Government will publish, in due course, an update on proposals for the future design of the public health system. These changes are driven by learning from the experiences of COVID-19, but more broadly by the need to ensure the country has a public health system fully fit for the future.

Safety and quality

Measures will be brought forward to **put the Healthcare Safety Investigation Branch (HSIB) on a statutory footing**; to **establish a statutory medical examiner system** within the NHS for the purpose of scrutinising all deaths which do not involve a coroner and increase transparency for the bereaved, and to **allow the Medicines and Healthcare products Regulatory Agency (MHRA)** to develop and maintain publicly funded and operated **medicine registries**.

Medicines registries

Medicines registries can consolidate prescribing data for specific medicines with data from clinical care and other social administrative databases and can be further developed to capture more detailed and bespoke data on the cohorts of patients receiving these medicines. The data captured in a specific medicine registry can help support the safe use of the medicine.

Medicine registries have the potential to be an important tool to support improving post-market surveillance of the use of medicines and help ensure consistent implementation of the highest standards of care.

Registries would be established for a medicine where the public need is clear and the benefits of a publicly held national registry that can access routinely collected data, where it is available, are required. Registries would help understand the impact of changes in risk minimisation measures on the health of patients and help us to understand how to ensure regulatory actions taken to support patient safety and clinical effectiveness are as effective as possible.

Measures will also be brought forward to **improve the current regulatory landscape for healthcare professionals** as needed. The White Paper explains that these proposed powers will make it easier to ensure that professions protected in law are the right ones and that the level of regulatory oversight is proportionate to the risks to the public, now and in the future.

These proposals form part of a wider programme to create a more flexible and proportionate professional regulatory framework that is better able to protect patients and the public. This will enable regulators to ensure that the processes that professionals have to go through to join and stay on a register are proportionate to assure public safety and are not overly bureaucratic. The proposals would support merging the functions of some regulators and the abolition of body's whose functions have been taken on by another organisation. The changes could potentially

also allow regulators to share functions, so for example, one regulator could maintain the register on behalf of another.

Patient Choice

The White Paper notes that integrated services provide an opportunity to offer joined up care to all and provide clear information on the choices people have in how and where their care is delivered. **A patient's right to choose where and who will provide their health and care needs will be preserved and strengthened** in the new system arrangements.

Under the new model, bodies that commission NHS services, as the decision-making bodies, will be required to protect, promote and facilitate patient choice with respect to services or treatment.

Data Sharing

Building on the successful data sharing in response to COVID-19, the Government wants to ensure that health and care organisations use data, when they can do so and with appropriate safeguards, for the benefit of individuals and the wider health and social care system.

In its recently published Data Strategy for Health and Care (Data saves lives: reshaping health and social care with data), DHSC set out a range of proposals to address structural, cultural/behavioural and legislative barriers to data sharing and a more flexible legislative framework to improve data access and interoperability, including enabling the safe sharing of data in support of individual care, population health and the effective functioning of the system.

As part of this work, the Government are exploring where achieving these objectives may require primary legislation. This includes proposals to:

- require health and adult social care organisations to share anonymised information that they hold where such sharing would benefit the health and social care system; and
- introduce a power for the Secretary of State for Health and Social Care to mandate standards for how data is collected and stored, so that data flows through the system in a usable way, and that when it is accessed/provided (for whatever purpose), it is in a standard form, both readable by, and consistently meaningful to the user/recipient.

Potential implications of the proposed changes for community pharmacy

National contracting

The key change in the White Paper and the associated NHSE&I document in relation to pharmacy contractors is the proposal to move the responsibility for the commissioning of NHS Pharmaceutical Services from NHSE&I regional teams to ICS NHS bodies.

This shift could be viewed as being not dissimilar to the previous approach to commissioning pharmacy services when this was led by primary care trusts, but with ICS covering larger geographical areas.

NHSE&I's continued commitment to national contractual arrangements across the primary care contractor professions is to be welcomed. However, any shift in responsibility for commissioning pharmaceutical services from one body to another has the risk of local adverse consequences for contractors, through the inevitable disruption to systems which accompanies such transitions. Previous such transitions have led to a loss of organisational memory in relation to the performance of key commissioning functions, as experienced staff who have undertaken key roles at a local level are lost within the reorganised system.

We note and support NHSE&I's intention to maintain nationally organised back office functions in relation to primary care commissioning, such as those provided by the NHS Business Services Authority and Primary Care Support England.

While the commitment to national contractual arrangements can provide protection of agreed funding at a national level, it is possible for funding distribution to be distorted at a local level, as is seen now in some cases, in relation to agreed medicines purchase margin (e.g. the application of branded generic purchasing policies by CCGs). Like CCGs, ICS will have the responsibility to balance the budgets they hold and there is a risk that the voice of primary care is drowned out in budgetary discussions by the calls for funding of the large NHS Trusts.

Local commissioning and integration

Commissioning all primary care services, via national contracting arrangements, via local NHS bodies potentially provides an opportunity to ensure the value of community pharmacy services is better recognised and maximised to the benefit of patients and the NHS through improved alignment of the delivery of nationally determined services within the primary care contracts with the work of other services providers within the health and care system.

The proposed changes, particularly the dissolution of CCGs, should provide the opportunity for better use of local commissioning of primary care services by the NHS and local government, without the issues that have been seen when much of this is driven by organisations whose governance is led by the representatives of one primary care profession.

Changes to legislation could afford the opportunity to allow community pharmacy services to be commissioned by NHS ICS bodies and local government via the administratively efficient Enhanced service route, under the provisions of the NHS Community Pharmacy Contractual Framework.

The delegation of decision making and budgets by the ICS to place level (generally the local authority area) could allow better alignment of local NHS commissioning and need, but robust governance systems will need to be put in place to ensure equitable decisions are made on commissioning services.

The importance of pharmacy engagement at PCN, place and system levels

The experience during the COVID-19 pandemic and the proposed changes both further reinforce the importance of PCNs and their position as the local building blocks of the health and care system.

However, as the NHS Confederation's PCN network has noted, PCNs nationwide are at different stages of development and while the pandemic has enabled many to progress, it has also prevented some from moving forward with key aspects of PCN service specifications.

The development of the role of community pharmacy PCN leads is still in its infancy and the need to provide more support to this group is clear. PCNs will clearly be an important way in which the voice of primary care providers is heard within ICS, so it will be important that community pharmacy continues to build its role and influence within PCNs.

The proposals for NHS ICS body boards suggest that the only primary care representatives present will be from general practice, but community pharmacy representation within ICS partnerships would seem to be a more realistic possibility.

Having a community pharmacy voice in discussions at ICS level will be important; pharmacy system leadership structures have already been created in many ICS, as a result of the NHSE&I Integrating NHS Pharmacy and Medicines Optimisation (IPMO) pilot programme. LPC support for these developments in all ICS continues to be an important priority.

Read the PSNC Briefing on the IPMO guidance and the development of pharmacy system leadership

The transition to the new system

NHSE&I have stated they will work with the representatives of primary care providers to plan the transition of contracting from NHSE&I to NHS ICS bodies and PSNC looks forward to playing our part in that work. NHSE&I have also noted that there may be a need for a longer timeframe for implementation of some of the changes to avoid local disruption to services; a phased implementation may be sensible and PSNC will discuss this with NHSE&I and DHSC if it is deemed appropriate.

The impact on Local Pharmaceutical Committees

Changes to the local structure of the NHS will inevitably have a resource impact on LPCs, as they adjust their operations to engage with the new organisations and seek to ensure community pharmacy is well represented in the new systems. LPCs have a key role in helping contractors navigate the local commissioning landscape and this will become even more important during a period of transition to emerging structures.

The geographical size of the current 42 ICS varies widely, with some being relatively small, aligned to both local authority and LPC areas, and some cover multiple local authorities across large areas, such as the north east and north Cumbria. Some ICS cover the patches of multiple LPCs and in these cases, most LPCs are already working collaboratively to engage with system leaders. All LPCs have been working to build relationships at system level since the development of Sustainability and Transformation Partnerships and this work will take on increasing importance, as will engagement and contribution in the pharmacy system leadership groups being developed as a result of the IPMO pilot and subsequent guidance.

The recommendations of the Wright Review into the representation of community pharmacy are currently being considered by the sector, led by the **Review Steering Group**; all concerned will need to ensure that any changes to local pharmacy representation works with the new NHS structures.

PSNC's role in the changes

PSNC has made an initial assessment of the potential implications and risks of the changes, as set out in this briefing and we will be working with Local Pharmaceutical Committees (LPCs) and others to consider this further and identify actions which are required to support contractors and LPCs.

Over the next few months, we will work with DHSC and NHSE&I to ensure that changes are implemented in a way which protects the provision of pharmacy services. Guidance and support will be provided to help contractors and LPCs to positively engage in the new NHS structures as they are formed.

If you have queries on this PSNC Briefing or you require more information, please email the **Services Team**.