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The new health and care system – a briefing

This briefing provides a quick reminder of the main commissioning organisations relevant to community pharmacy from 1st April 2013 and an update on the current issues related to the changes to the health and care system.

It outlines the roles of some of the key organisations within the reformed NHS as well as some of the actions that LPCs may want to be considering. More detailed briefings on these organisations are being prepared by PSNC and will be published over the coming months.

NHS England (formerly the NHS Commissioning Board)

The NHS Commissioning Board started to use a new name, NHS England, on 1st April (the NHS Commissioning Board is however still the name used in legislation to describe the organisation). NHS England is responsible for commissioning the national community pharmacy contract as well as the other primary care contracts for general practices, dentistry and optometry. It is also responsible for some nationally commissioned public health services such as vaccination programmes, e.g. seasonal flu vaccination, and national screening programmes.

NHS England is also responsible for specialist services commissioning (e.g. regional provision of treatment for rare cancers), offender healthcare, services for members of the armed forces and oversight of Clinical Commissioning Groups (CCGs).

NHS England's Area Teams (ATs) are the 'local' arms of the organisation and they are part of the operations directorate. The 27 ATs are the part of NHS England which pharmacy contractors and LPCs will have most contact with. Many PCT staff are being transferred to ATs, however they will be much leaner organisations than their predecessor PCTs.

The ATs will be responsible for determining applications for pharmacy contracts, contract monitoring, opening hours and EPS support. Some roles of NHS England, such as provision of support for EPS, may be provided by other organisations such as the local Commissioning Support Unit, working under contract to the AT.

PSNC has suggested to NHS England a number of ways in which current PCT responsibilities could be more effectively undertaken from 1st April. Examples include:

- choosing some of the six public health campaign topics as national topics, which all pharmacies would undertake at the same time, thus having a greater impact on the public. This approach could involve community pharmacies supporting national DH-funded campaigns, such as Be Clear on Cancer;
- selecting a national topic for the former PCT-led clinical audit in order to increase administrative efficiency and to support the collation of data on community pharmacy's contribution to the NHS and patient care.

The rapid pace of the transition to the new health and care system has meant that the senior policy makers at NHS England have not yet had time to consider how changes to the current PCT pharmacy management functions could benefit its operational efficiency. As an example of this, a lot of the current family health services (FHS) staff in PCTs or associated agencies have been 'lifted and shifted' into NHS England for one year, as it was not possible to create a new, more efficient way of undertaking their work prior to 1st April.

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In conversations with senior NHS England staff it is clear that there is still an appetite to consider better ways of working with regard to the organisation's relationship with pharmacy contractors and PSNC will be seeking to persuade them of the value of changes to some systems over the first few months.

Each AT will have three **Local Professional Networks (LPNs)** covering pharmacy, dentistry and optometry. The LPNs are intended to provide clinical input into the operation of the AT and local commissioning decisions. They will also be the focus for NHS England's work on quality improvement for the three local services. CCGs will undertake a similar role for their constituent medical practices.

NHS England has stated that LPNs will:

- support implementation of national strategy and policy at local level;
- work with other key stakeholders on the development and delivery of local priorities, some of which go beyond the scope of primary care commissioning; and
- provide local clinical leadership.

Pharmacy LPN specific functions include:

- supporting local authorities with the development of the Pharmaceutical Needs Assessment (PNA);
- considering new programmes of work around self-care and long term conditions management in community pharmacy to achieve Outcome 2 of the NHS Outcomes Framework;
- working with CCGs and others on medicines optimisation; and
- 'holding the ring' on services commissioned locally by local authorities (LAs) and CCGs, highlighting inappropriate gaps or overlaps.

Current development of LPNs across the 27 ATs varies enormously; those areas which piloted the concept of LPNs are unsurprisingly further ahead than those not involved in pilots. A **draft operating framework for LPNs** has been developed and shared with ATs for their comments. PSNC has sent this framework to LPCs for comment.

The framework highlights the relatively small resource that will be available to support LPNs; this may constrain the operation of many networks, however there is a clear drive from NHS England for LPNs to be created as soon as possible, where they don't already exist. Some ATs have commenced the recruitment process for the chairman of their pharmacy LPN, via adverts placed on www.jobs.nhs.uk.

Local Authorities (LAs)

The 152 'top tier' LAs are now responsible for commissioning the majority of public health services; county councils and unitary authorities are classed as 'top tier' authorities.

Each LA has a **Health and Wellbeing Board (HWB)** which will have a wide remit across the new health and care system, providing strategic oversight and bringing together all the local commissioners. HWBs will not commission services; that will be undertaken by the LA. LPCs have reported that current priorities for HWBs include matters such as housing and the care of older people.

LAs and CCGs have equal and joint responsibility for producing the Joint Strategic Needs Assessment (JSNA), through the HWB. The JSNA and the Joint health and Wellbeing Strategy (JHWS) will inform the preparation of the Pharmaceutical Needs Assessment (PNA) which will be used by the AT to determine some applications for pharmacy market entry.

In most LPC areas existing locally commissioned public health services are being rolled over to the LA, often for 12 months after which the contract comes to an end and the service will be reviewed and may be re-commissioned.
Some LAs are using the standard public health contract published by the Department of Health as the basis for all contracts for locally commissioned public health services provided by pharmacies. While there is no legal duty on the LA to consult the LPC on the commissioning of public health services, many have already done so; clearly positive relationships between the LPC and LA officials increases the likelihood of this occurring.

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Clinical Commissioning Groups (CCGs)

CCGs have responsibility for commissioning health services (as opposed to public health services). All GP practices within the area of the CCG are 'members' of the CCG. One of the early priority areas for all CCGs is effective commissioning of hospital services and as a consequence they may have less of a focus on the opportunities for commissioning services in primary care in their first year of operation.

For community pharmacy, CCGs may wish to commission services such as minor ailments services, palliative care schemes, MUR+ and other medicines optimisation services.

The role of LPCs

LPCs continue to work hard to build relationships with new commissioners and to secure the future of locally commissioned services for their contractors.

Some actions your local LPC may be considering at the moment include:

- Making early contact with the AT Director and their team to reinforce NHS England's recognition of the LPC and to ensure the AT staff are aware of the role of the LPC;
- Using their expertise on the market entry regulations gained from PSNC training events in 2012 to make sure the AT properly applies the market entry regulations so that existing contractors are not adversely affected by procedural errors;
- Getting involved with the work of the LPN and using it as a vehicle to promote community pharmacy;
- Promoting PharmOutcomes to LAs as an efficient solution to managing services; several LAs have already agreed to use PharmOutcomes. The extra benefit is that PharmOutcomes will help collate data on the service to support the case for re-commissioning;
- Attending HWB board meetings to develop relationships with key players on the HWB and to network with other stakeholders;
- Identifying and working with the relevant LA personnel to ensure the PNA is up to date and fit for purpose;
- Attending CCG meetings to develop relationships with key players on the CCG Board;
- Identifying which Board members are leading policy on clinical areas where community pharmacy can make a difference, e.g. diabetes or COPD, so they can target messages to the right person;
- Identifying key individuals within CCGs who lead policy on health inequalities, urgent care and prescribing;
- In the first few months the new commissioning organisations will still be finding their feet and will have competing priorities on their time; make a judgment as to the best time to seriously engage them on pharmacy matters; And
- Supporting contractors to deliver the existing national contract in particular MURs and NMS; this helps in the national discussions to expand the range of services within the core contract.

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