



Integrated Care
Systems Network
NHS Confederation

From delegation to integration

Lessons from early delegation of primary pharmacy, optometry
and dentistry commissioning to integrated care boards

April 2023

About us

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

The Integrated Care Systems Network is part of the NHS Confederation. As the only national network bringing together the leaders of health and care systems, it supports ICS leaders to exchange ideas, share experiences and challenges, and influence the national agenda.

Contents

- 2** About us
- 4** Key points
- 6** Introduction
- 7** Methodology
- 8** The existing POD commissioning landscape
- 10** The process of delegating POD services
- 12** Transition challenges and opportunities for POD commissioners
 - 14 Governance arrangements for the transition
 - 15 POD commissioning data requirements
 - 18 Increasing engagement with systems
 - 20 Transition capacity
 - 22 Improving quality and access
 - 23 From transactional to transformation: service transformation opportunities
- 27** Empowering changes: ICBs' future support needs
- 29** Viewpoint and recommendations
 - 30 Recommendations for integrated care boards
 - 31 Recommendations for NHS England
- 32** Annex: POD commissioning roles and responsibilities under delegation
- 33** References

Key points

- Delegation of primary pharmacy, optometry and dentistry (POD) from NHS England to integrated care boards (ICBs) on 1 April 2023, provides an opportunity to transform care for patients but will need a realistic timetable and smooth transition if this transformation is to be achieved.
- This report provides evidence from nine ‘early adopter’ ICBs and argues that closer local collaboration between NHS systems and frontline providers can be the single biggest driver to address local provision challenges.
- Early adopter POD commissioners identified immediate transition challenges including ensuring adequate governance is in place, understanding and meeting commissioner and provider data requirements and developing effective engagement mechanisms with local providers.
- Access to and capacity to use appropriate data is most urgent to identify unmet patient need and ensure service quality. Meanwhile, clarity over flexibility within national contracting arrangements, particularly for dentistry, is needed and opportunities for further reform considered.
- NHS England needs sufficient ICB capacity, particularly in relation to dentistry where there is mounting evidence that some dentists have been reducing their NHS activity or ceasing to offer NHS services. Within its broader workforce planning, the government must develop a clear approach to the dentistry workforce crisis.
- Delegation provides an opportunity to support increased autonomy at a local system level, backed up by appropriate regional and national support, which can improve access to services and improve health outcomes. To maximise the potential benefits, support from NHS

England needs to avoid risk aversion, permit innovative approaches to improving health outcomes and reducing health inequalities, and not create barriers to implement different approaches.

- For ICBs, the immediate task will be to manage the logistical and governance challenges of shifting the management of these contracts and they should invest time and effort in building relationships with POD service providers, as well as wider stakeholders.

Introduction

On 1 April 2023, responsibility for commissioning pharmaceutical, general ophthalmic services and dentistry (POD) was delegated to integrated care boards (ICBs) with the aim of moving towards primary care services that are more joined up,¹ locally led and locally responsive. The plans were announced by NHS England in 2021 as part of a range of commissioning reforms initiated by the Health and Social Care Act 2022.

It is hoped that bringing together management of these primary care functions at a system level will enable a stronger voice for primary care providers, patients, the public and other key stakeholders in service design and delivery at a local level. Devolving commissioning to a system level also helps ICBs to achieve the aspirations of the Fuller Stocktake, to improve access to care and advice, deliver more practice care and help people to stay well for longer.²

To test the process and provide insight into how this transition might work, nine early adopter systems took responsibility for commissioning some or all of the POD services in July 2022.

For ICBs taking on POD functions in April 2023, the immediate task will be to manage the logistical and governance challenges of shifting the management of these contracts from NHS England's regions to a system footing. The complexity of this process should not be underestimated and this report helps to aid this process.

It draws on the experiences of early adopters and their partners working at national and local levels in provider membership associations for POD services. Drawing on these people's experience, it highlights challenges, opportunities and lessons learned, both in relation to the immediate process of delegating commissioning arrangements and longer-term transformation plans.

Methodology

The NHS Confederation's ICS Network worked with the nine ICBs assuming delegated POD functions across several months in 2022/23 to share learning and approaches to taking on delegated functions. This report is based on the engagement and discussion with POD leads and provider representatives to capture the reflections. We would like to thank all those who have been involved and contributed to its development. While we have endeavoured to capture and reflect the experiences of our members, this report sets out the view of the NHS Confederation and not necessarily that of any single ICB involved.

Table 1 : The POD early adopters

- Buckinghamshire Oxfordshire and Berkshire West ICB
- Cheshire and Merseyside ICB (pharmacy only)
- Frimley ICB
- Greater Manchester ICB
- Hampshire and Isle of Wight ICB
- Kent and Medway ICB
- Lancashire and South Cumbria ICB (pharmacy only)
- Surrey ICB
- Sussex ICB

The existing POD commissioning landscape

National contracts or contractual frameworks have generally been used for the bulk of the activity undertaken for all three POD services, but there is some variation in the extent to which supplementary local commissioning arrangements have been put in place.

In pharmacy, national contract negotiations take place via the Community Pharmacy Contractual Framework, but there is a stronger track record of local commissioning, alongside well-established links between community pharmacy and ICB medicines management teams.

In some areas, pharmacies have been providing locally commissioned public health services for some time. During the pandemic, the NHS was able to capitalise on these existing ways of working, when some community pharmacies worked with primary care networks to coordinate the delivery of COVID-19 vaccines locally, while others contracted directly with NHS England via a national enhanced service.³

Ophthalmic services are commissioned under the Any Qualified Provider (AQP) programme, with terms, fees and grants for the general ophthalmic services contract negotiated nationally. While the AQP programme, commenced in 2012, has opened up opportunities for new providers and potentially wider access for patients, it is questionable as to whether these services are usually located in areas where there is greatest deprivation and highest need.

Primary care dentistry is negotiated nationally under the general dental services contract, with some additional locally agreed contracting arrangements, for instance for emergency dentistry. ICBs will also be taking on responsibility for other dentistry services sitting both outside and within primary care such as oral surgery and orthodontics. This provides an opportunity for increased collaboration, transformation and integration with community, urgent and emergency care services and oral-maxillofacial and orthodontic services.

The process for delegating POD services

Schedule 3 of the Health and Social Care Act 2022 permits NHS England to delegate responsibility for commissioning some primary care services that had previously been commissioned centrally.⁴ The plan to delegate commissioning of the three services, collectively known as the POD services, to ICBs by April 2023 was revealed at the same time as it was announced that ICBs would take over the delegated commissioning of primary medical services from clinical commissioning groups. Primary medical care was delegated to all 42 ICBs in 2022.⁵

Under the new approach, ICBs will assume responsibility for commissioning activity, but NHS England retains overall accountability for the discharge of the POD functions, as well as for primary medical services, under the act.

NHS England will use a primary care commissioning assurance framework⁶ to assure itself that ICBs are exercising delegated primary care functions ‘safely, effectively and consistently within legislation and statutory guidance’.⁷ NHS England is also in the process of preparing a toolkit to support the people commissioning POD services within ICBs.

Annex 1 shows new roles and responsibilities at national, regional and ICB level, following the changes.

This change in role for NHS England presents an opportunity to support increased autonomy at a local system level, backed up by appropriate regional and national support. To maximise the potential benefits of this new relationship, this support needs

to permit innovative approaches to improving health outcomes and reducing health inequalities, rather than creating barriers for systems looking to implement different approaches. All parts of the system, from the national to the regional and system level, will need to change to accommodate this collaborative way of working, with clarity on roles and responsibilities.

Transition challenges and opportunities for POD commissioners

An effective transition for POD services is necessary to create a climate where the considerable opportunities presented by closer working relationships between systems and providers in partnership with patients, the public and local stakeholders can be realised.

As early adopter ICBs have begun to engage with POD services, they have learned much about the current state of the contractual arrangements and the performance of POD providers against their contracts. Integrated care systems are taking on responsibility for services that may not be, at present, performing at the anticipated level of clinical quality or patient access across all areas, with contracting challenges remaining for some providers, and many primary care-based services still dealing with the aftermath of the pandemic.

Of the three POD services, dentistry arguably poses the greatest immediate challenge for systems. Current contracting arrangements are unpopular with primary care dentistry providers, with issues over the level of reimbursement for activity, as well as disincentives related to pension and tax arrangements that have affected other providers using independent contractor models such as GPs. As a result, some dentists have been reducing their NHS activity or ceasing to offer NHS services altogether, hindering the NHS's capacity to delivery dentistry services.

A 2016–19 pilot of a prototype dental contract carried out under the dental contract reform programme failed to achieve its aims. The pilot had intended to improve oral health through prevention of caries and periodontal disease and increase access to NHS dental care for patients, as well as address concerns from the dental sector about remuneration. However, although an increased level of activity was delivered in individual courses of treatment at prototype practices, this activity was across a smaller number of patients and fewer courses of treatment.⁸

An underspend in NHS England’s dentistry budget is anticipated in 2022/23 as dentists are delivering significantly lower volumes of activity than they are contracted for, primarily citing that the NHS payment for units of dental activity (UDA) does not cover the costs of work.⁹ Moreover, the current model of provision is unpopular with service users: 54 per cent of people in a representative sample of 2,026 English adults in 2022, who had used a dentist, reported they had experienced a problem.¹⁰ With delegation, ICBs will be able to reinvest any underspend in these services within the existing financial year, but as per public spending rules, this cannot be rolled forward into subsequent financial years.

Leaders working in the early adopter systems interviewed for this report told us that the **following areas were important early steps** for new system-based POD commissioners:

1. Putting in place **effective governance** for the transition.

2. Ensuring **access to the right data**.

3. Setting up structures to **engage local providers**.

5. Understanding and **addressing capacity issues** for ICBs and providers.

4. Developing a process to **assure quality locally**.

However, this onboarding process has consumed significant time and effort. The next stage of this process is focused on transforming services, to be achieved once POD services are well bedded in.

Governance arrangements for the transition

ICB leaders told us that governance is an important early consideration when beginning the transition of responsibilities. Getting the governance right can take time and differences in ICS governance, population needs and wider circumstances mean that 'one size fits all' approaches are not appropriate. Where new contracting arrangements are used, excessively risk averse governance arrangements to counter their untested nature should be avoided as this can act as a drag on transformation.

These governance challenges ranged from ensuring that the right people were present on the right committees in the ICB, to ensuring that existing funding streams and contracts were married up in new systems as part of a robust due diligence process.

Some early adopter ICBs have reported that having a stronger provider voice in strategic decision making – possible because of the shift away from a clear commissioner/provider split – has been beneficial and feasible, while maintaining good governance.

Governance must also extend beyond the delegation of contracting arrangements to cover human resources requirements relating to any staff who might be moving across into ICB roles. If regional POD commissioning expertise is to be divided and dispersed across ICSs, there are concerns that some ICSs could be left without depth of access to experienced and expert staff.

POD commissioning data requirements

One of the most pressing tasks for ICBs taking on POD commissioning management functions is to ensure that they have access to the full data sets they need. We found that there was variance in what data different adopter systems could access.

Linking data about the availability of POD services to local population health needs assessments will be important in helping to understand obstacles to accessing services and where access needs to be improved. It will also be key for ICB commissioners to encourage colleagues working in local authority public health teams to work with them to describe the need for POD services in Joint Strategic Needs Assessments (JSNAs).

Although JSNAs currently cover dentistry, they are not required to have content on optometry and pharmacy, and there is some variability in terms of the degree to which POD services feature. There is the potential for JSNAs to play a valuable role in the mapping of services to population need, for instance building on health and wellbeing boards' pharmaceutical services needs assessment.¹¹

Some early adopter systems have used a project management approach to maximise opportunities to support data transfer between POD commissioners in the regional tier of NHS England and ICBs. Case study 1 (below) describes Cheshire and Merseyside ICB's 'sender receiver' and 'deep dive' processes for transferring data from incumbent commissioners to the new POD commissioning team.

In terms of service-level data to inform commissioning activity, early adopters told us that the availability of data varies between the different POD services.

For primary care dentistry, there is less available data at practice level than in general practice, since dentists do not keep registered lists. For urgent care dentistry, more data is available, for instance

relating to 111 calls and accident and emergency visits for dental problems. That said, commissioners point out that they do already have sufficient dentistry data to tell them when they do not have enough available primary care dental slots. Currently, dental activity monitoring does not measure the prevalence of poor dental health, it is assumed those with poor access to services simply do without such clinical care.

There are important links to be made between oral health and health inequalities. Having access to better primary care dentistry data is necessary to take a population health management approach to oral health. In its 2021 report, Public Health England pointed to a 'paucity of evidence on whether and how community-level and service utilisation interventions impacted on oral health inequalities'.¹²

In dentistry, improving the availability of local activity data is important to support high-quality commissioning decisions in the short term and to enable systems to tackle more entrenched oral health inequalities over the longer term. Accurate data will also support the systems' workforce monitoring.

Dentists themselves face challenges as a result of lack of access to data. They are not able to access the NHS summary care record and must contact GP practices to access information about patients' medical conditions that could be relevant to their oral health.

In pharmacy, access to data is a mixed picture. Some pharmacy groups have their own systems for generating data, whether individually as a collective of local pharmacy committees, or as a group of companies. In other areas, health systems have data systems in place, but in some areas, data generation is less well developed.

For the community pharmacy sector, generating high-quality data is important to demonstrate the impact of new services in reducing

pressure in other parts of the primary care landscape such as general practice. For instance, when patients with a particular condition are diverted away from general practice to pharmacy for an aspect of condition monitoring, it is important for both providers and commissioners to understand what outcomes were achieved for that cohort of patients. This is a vital component of ICSs' ability to look at the financial impact of interventions across the whole system and drive NHS productivity.

Case study 1: Cheshire and Merseyside's 'sender receiver' and 'deep dive' approaches to migrating POD services

In Cheshire and Merseyside, ICB staff took on responsibility for managing the community pharmacy functions in 2022. During this period, the existing NHS England teams were aligned with the ICB and continued with the business as usual – this was important as the day-to-day business did not stop. The same process is now underway for dentistry and ophthalmic services.

The Cheshire and Merseyside system gave a team member in the ICB's project management office a dedicated project manager role overseeing the process of transferring contracting functions. Chris Leese, associate director of primary care at the ICB, describes the project manager as playing an important 'critical friend' role, supporting the busy ICB team to embed the new commissioning functions while continuing to perform their existing roles.

The ICB set up a task and finish group and used an approach called 'sender receiver', where different staff performing existing functions in areas such as finance and digital at the regional level were partnered with ICB staff who would be taking on those functions. The 'receiving' staff were then able to access information about the specific functions that they would be taking on directly from the incumbent staff. As a



result, the teams were able to break down a large complex task into smaller, more manageable components. The system has developed a handover document for dental and one for optometry, in the spirit of the sender/receiver approach, from NHS England to the ICB.

Now that the immediate tasks have been addressed via the sender receiver process, the ICB is putting in place 'deep dive' meetings for dental contracting, where different stakeholders are brought together to discuss risks, challenges and the strategic direction of the service. This engagement is broad, involving local HealthWatch and MPs as well as local service providers and others directly or indirectly involved in the provision and commissioning of care, such as public health colleagues and representatives from Health Education England.

Increasing engagement within systems

As POD commissioning has not been a CCG responsibility in the recent past, levels of engagement with POD providers vary across systems. Some engage regularly with dentists and pharmacists whilst in other systems these providers struggle for a voice. Such engagement and collaboration is part of both the intention and design of ICSs and crucial to realising the full opportunities presented by delegation.

Table 2: Example local provider committees

- Local dental committee
- Local pharmaceutical committee
- Local optical committee

Moving POD commissioning management functions into local systems, alongside primary medical care commissioning, offers the potential to build networks between the different elements of primary care and to work towards more holistic local primary care provision.

Realising this ambition will be a long-term project for ICSs, but an important early task is to begin to establish the structures that will support better dialogue across all primary care functions.

Several early adopter systems have created primary care panels to enable different parts of the primary care provision landscape to come together and to support a better dialogue between primary and secondary care (case study 2). Local professional networks (including local eye health networks, local dental networks and local pharmacy networks) and their clinical leader can play a role and contribute to service planning. As the NHS Confederation has previously highlighted, continued clinical leadership should remain a vital part of commissioning in a system landscape.¹³

Engaging relevant stakeholders at a system level is important to drive service improvement and joined-up services, but the multitude of relevant stakeholders can be challenging given ICBs' finite capacity. In addition to providers, ICBs will need to consider how to best to engage patient representatives, Healthwatch, voluntary sector groups and local authorities in planning and redesigning POD services.

Case study 2: Building primary care provider engagement structures in Surrey Heartlands

Surrey Heartlands ICB has focused on engaging primary care providers at all levels of decision-making within the system by establishing clinical committees and supporting primary care clinicians to engage.



Surrey Heartlands' Health Care Professional Committee (HCPC) focuses on setting clinical strategy, for example scrutinising redesigned clinical pathways. The Primary Care Professional Advisory board (PCPA) includes members of the various professional bodies for out-of-hospital services operating within primary care locally.

The PCPA facilitates dialogue between providers to support better integration of services and has a role in disseminating the decisions of the HCPC. It ensures that there is a primary care provider voice at executive level.

The PCPA is also the voice of the Primary Care Provider Collaborative, which is intended to ensure that primary care providers have a route to discuss services with provider collaboratives in the acute and mental health sectors. This is particularly important for service areas like optometry and dentistry, which have primary care and secondary care components within specific pathways.

The ICB is working via its committees in common to find a way to support other primary care professions financially to engage with the ICB in meaningful conversations, in the same way that it has done for GPs.

Surrey Heartlands ICB director of primary care Nikki Mallinder says: "The most important part of all of this is building relationships and trust, and that takes time."

Transition capacity

ICBs' capacity to manage the transition of POD functions, engage and understand POD providers' capacity and to drive

transformation has been challenging. Forthcoming reductions in ICBs' running cost allowance, which funds commissioning and engagement capacity, will add to this pressure.¹⁴ NHS England is currently consulting on the transfer of staff supporting POD commissioning from NHS England regional teams to ICBs.¹⁵

Several systems told us that freeing up capacity within ICBs to carry out the work required to move contracts into local systems, while continuing to 'do the day job', or in other words double running, was a challenge. While some ICBs such as Cheshire and Merseyside (case study 1) have been able to align staff from different parts of the system to support the work, it is unclear whether this will be possible for every ICB. Working across ICBs via committees in common may be another route to increasing the efficiency of the transition process.

Regardless of the arrangements in use to delegate services into ICBs successfully, early adopter ICBs were in agreement that transforming services was not possible at the same time as transitioning them into systems. While some transformation has continued during early delegation, the greatest opportunities for transformation lie in the next phase once the transition is complete.

Where provider capacity is concerned, there has been little opportunity to date for using multidisciplinary approaches or delegating clinical tasks. There is significant consensus on the need for reform in dentistry. NHS England has a contract reform programme in place and completed a first set of reforms in 2022, with enhanced UDAs for higher need patients, a minimum indicative UDA value and removal of some administrative barriers preventing dental care professionals from operating within their gull scope. This is welcome and provides more opportunities for maximising access to services from existing NHS resources and improve information for patients.¹⁶

While welcome flexibilities were added to the dental contract in 2022, several ICBs reported that the dental contract still holds

back desired transformation. It is not clear that new flexibilities are necessarily well understood but there is also potential for further reforming the contract to enable transformation.

Where workforce planning is concerned, longstanding challenges have still not been addressed by the government and it needs to develop a clear approach to the dentistry workforce crisis. The NHS workforce plan provides an opportunity to address this, as the NHS Confederation has been urging for some time.¹⁷

At the same time, system partners note opportunities for integration and collaboration with secondary care that could increase access to NHS dental services and provide enhanced career development for dentists that could be facilitated through the existing secondary care infrastructure. Examples include managing the emergency department ‘back door’ with out-of-hours NHS dentistry provision and making better use of the oral surgery department, theatre capacity and newly qualified dental house officers. Local service planning provides an opportunity to consider and implement such models to improve access to care.

It is possible that ICBs may be able to develop local solutions, given the right contracting levers, but it is unlikely that new leadership of POD commissioning will be able to develop such approaches without clarity on contracting arrangements and support to address short-term capacity issues.

Improving quality and access

Early adopter ICBs have been concerned that they did not have sufficient access to the right data to fully assess the clinical quality of their providers. This creates a real dilemma for the ICBs in terms of whether or not they should take on this responsibility without full oversight of the quality of service delivery. Systems need to be able to baseline their data on providers effectively, particularly in terms of the quality of services delivered, so they can truly measure improvements in services.

Across POD services, the most pressing access need relates to NHS dentistry. Access was limited during the pandemic, with 10 per cent of participants in the 2021 oral health survey who had sought dental treatment or advice reporting that they did not receive any advice or treatment.¹⁸ Unmet need during the pandemic has the potential to result in increased demand for both routine and urgent dental care in the coming months and years. This potentially extends beyond oral health to oral cancers and disease that may have not been identified by dentists.

A recent report by Public Health England acknowledges that barriers to NHS dental care exist at an individual, societal and policy level. These include costs, lack of availability of services, and services that are not commissioned to meet local needs.¹⁹ These issues are also key public concerns and Healthwatch England has reported that ‘access to NHS dental care continues to be one of the main issues we hear about from the public.’²⁰

In optometry, increasing levels of referrals into independent sector providers of NHS care for high-volume/low-acuity procedures, such as cataract surgery, may have implications for acute ophthalmology pathways and for acute clinicians, where case mix changes result in acute staff taking on a higher proportion of complex cases. Systems will need to consider how the optometry pathway works, to ensure that referral processes operate effectively, patient choice is preserved, and pre- and post-surgical support services are considered as part of this area of provision. An important element of this will include supporting the establishment of eye health networks, which are under-resourced at present.

From transactional to transformation: service transformation opportunities

The early months of delegation have been focused on inheriting transactional business around POD services, with early adopter systems seeing transformation of POD services as a task for the

future. POD commissioning leads at early adopter systems are clear that ambition and significant service transformation is needed to tackle health inequalities of access and quality of services. Only then should national contracts be negotiated, not the other way around.

An early part of this transformation task will involve assessing population need and supporting providers to reconfigure their services to meet local requirements. Early adopters see a critical part of this process as moving the commissioner-provider relationship from a transactional model to a deeper relationship. This is where ICB-level commissioning of POD services, with commissioners working within the same systems as providers, establishing closer relationships and better understanding the pressures they face has great potential (see case study 3).

Dialogue at the level of place will be an important part of service transformation work. Some early adopter systems have already begun conversations with local public health leads, MPs and other stakeholders to ensure that plans are informed by place-level perspectives.

One important area where it may be possible for ICB commissioners to have an early impact is in identifying struggling providers before their challenges become critical and stepping in to support their recovery. General practice has provided a model for this type of approach, but it is not yet clear to systems how much freedom they will have to make similar arrangements with POD providers.

Where transformation plans require a provider that has not traditionally performed a particular function to move into this area, this can pose a challenge both for incumbent and new providers. For instance, some systems spoke of GPs being reluctant to allow pharmacists to take on hypertension case management work because they feared it would simply add to their workload.

In these situations, a combination of stronger local relationships, improved engagement and better data is likely to offer part of the solution. If overstretched incumbent providers can be persuaded to test new models, and the impact of these models can be demonstrated through improved data (for instance, pharmacy activity data showing GP visits for hypertension case management prevented), then this should provide a route to sustained transformation of care.

Commissioners are still unsure of how transformational they can aspire to be and would welcome ongoing contact with national-level policymakers, who can ensure that guidance is interpreted consistently across the country and empowers local leaders to deliver change. Once again, this is particularly important in respect of dentistry, where a large number of dental pathways including some with relevance beyond primary care are to be devolved to local systems.

Case study 3: Transforming primary care in Greater Manchester

Greater Manchester ICB has made fast progress on the delegation of POD services, building on established governance arrangements from the establishment of the Greater Manchester Health and Social Care Partnership and devolution deal. As a consequence, pharmacy, optometry and dentistry commissioning are already embedded within the Greater Manchester system. POD services are now part of system-wide considerations when issues such as winter pressures and recurrent and non-recurrent investment are being discussed.

The Greater Manchester primary care board, a strong provider collaborative for primary care colleagues, has been establishing quality initiatives across POD and primary medical care, as well as considering the services from population health and primary care perspectives.



Commissioners in Greater Manchester have looked for local commissioning opportunities and explored how they might achieve local goals within the parameters of national expectations. For example, a transformational approach to integrating oral health across health and care, bringing investment into different settings and addressing the oral health challenges not just as a dental services issue.

All of the changes made to date have happened within national frameworks, contracts and regulations. ICBs face the challenge of delivering their ambitions to transform local services while continuing to work within the current regulatory frameworks. Experience to date has indicated that there are limitations to make changes which national contracting arrangements still do not permit, despite the devolution arrangements. There are opportunities permitted within national regulations to create new approaches, working with contracting tools that are already in place, but to achieve the ambition of ICBs greater flexibility is required.

Ben Squires, head of primary care at NHS Greater Manchester Integrated Care, predicts that this is an area where all ICBs are likely to experience challenges. He says: “For ICBs to be able to make the most of POD delegation and opportunities for local service development and integration it is important that NHS England allows them to maximise the flexibility within existing regulations and contractual tools but also contribute to the future design of regulatory arrangements, ensuring that the ICBs and local systems have expertise and skills in this area.”

The ICB has been able to encourage greater collaboration at the neighbourhood level through a culture of local ownership and has used this to achieve progress on working across the primary care services and with other local partners such as the VCSE sector. This local ownership has seen some valuable developments, such as making primary care services more environmentally sustainable and support between providers to help services respond to challenges and pressures.

Empowering change: ICBs' future support needs

While some ICBs have clearly been able to put effective processes in place to transfer knowledge and data during the transition, this has not worked optimally across the board. Ensuring that clear expectations are in place regarding data and knowledge transfer and that template processes for doing this are articulated, is likely to be beneficial to systems following in the early adopters' footsteps.

It will be important to clarify the extent to which local commissioners are able to move beyond transactional contracting relationships and offer bespoke local support packages when POD services are under pressure, if ICBs are to attempt to stabilise these services. But to do so requires clarity about what is possible within the constraints of the national contracting approach.

As described earlier in this report, ensuring adequate primary care dentistry provision is one of the most significant challenges facing commissioners of primary care services at present. Commissioners told us that they had been able to put elements of support in place for general practitioners who were facing challenges when providing services, but that they were unclear about the degree to which they might be able to provide similar support for dentists or optometrists.

NHS England has committed to providing guidance on the options available to ICBs regarding the flexibilities that are permitted within the national dental contract. Sharing this information with POD commissioners should be an early priority for NHS England.

NHS England emphasises that it will still be necessary in future to perform some tasks centrally, since national contracts must be negotiated and maintained at a national level. But since NHS England will devolve its role in service delivery, implementation and contract monitoring, it is imperative that ICBs are supported to get up to speed with these functions quickly.

It will also be necessary to manage expectations both within systems and nationally in terms of what improvements service users, providers and NHS leaders should be able to expect in the short to medium term from these services, given the volume of work required to onboard delegated functions in ICBs.

Viewpoint and recommendations

The experiences of POD early adopters suggest that the delegation of POD commissioning tasks to local systems presents opportunities to address some longstanding problems in pharmacy, optometry and particularly dentistry. However, significant challenges exist for commissioners, in terms of the work needed to delegate these services effectively, to ensure commissioners are on a secure footing to make the necessary changes.

Early adopter POD commissioners have identified immediate transition challenges including ensuring adequate governance is in place; understanding and meeting commissioner and provider data requirements; and developing effective engagement mechanisms with local providers. Sufficient ICB capacity is needed to complete transition tasks and establish building blocks of quality improvement, such as baseline performance information. These are not challenges unique to POD delegation, but also shared more widely across other areas of ICB establishment.

Once these steps have been completed, opportunities exist in terms of establishing less transactional relationships with POD providers, engaging with patients and local stakeholders, configuring services in a way that is more responsive to local need and establishing processes to support challenged providers and avoid chaotic market exits. Relations and support between ICB leads has helped them to get to this stage and will remain important as they seek to accelerate transformation.

Commissioners will need time to reach the point where these opportunities are achievable. Therefore, managing expectations around the transition and ensuring system-level commissioners

are able to access well-designed transition support toolkits and detailed service information will be critical for the achievement of both short-term transition objectives and long-term service transformation goals.

Recommendations

Our findings set out in this report suggest the following changes – some led by ICBs and others by NHS England – will support national, regional and local systems to ensure that the delegation is as smooth as possible and maximises the potential for ICSs to transform services and deliver improved access and care for patients.

Recommendations for integrated care boards

- 1. Timescales.** While systems should rightly be ambitious in trying to deliver change and improvement in POD services, all system partners need to be realistic about the pace of change. During early delegation, ICBs have needed time to assume and adapt to POD commissioning before they are ready to begin transforming services. ICBs should be honest with providers, patients and the public about the pace of change and manage expectations.
- 2. Provider relationships.** The rationale and benefits of system working are premised on different partners involved in delivering services working closely together to drive improvement. Within the constraints imposed on their capacity, ICBs should invest time in building relationships with POD providers who can help to drive and lead service transformation, including but not limited to harnessing the expertise within provider committees. This is important to laying the groundwork for using delegation to improve care. POD providers, for their part, should be prepared to step up with ideas for change and play a role in collaborative system leadership.

Recommendations for NHS England

- 1. Empowerment.** Delegation of formal functions is just the start of enabling local transformation. NHS England should seek to empower systems as much as possible with the flexibility to take new approaches and innovate. Central support should focus on building ICBs' capacity and intelligence without being too prescriptive.
- 2. Governance.** While robust governance is essential to ensure the quality and safety of services commissioned, governance requirements should be proportionate so they do not consume excessive capacity. NHS England should seek to further streamline governance requirements around transition, so systems can spend more time planning and designing service transformation work.
- 3. Data.** Timely and sufficient data, together with the capability to analyse it, is essential to strategic commissioning, enabling ICBs to identify unmet need in their populations and ensure the quality of services. Early adopters of delegated POD commissioning felt they need improved access and ability to analyse data. NHS England should support ICBs to access and analyse data from different sources to identify population need and oversee service quality.
- 4. Dentistry capacity.** Challenges with accessing dentistry services are well documented. ICBs are eager to use the opportunity of delegation commissioning to transform pathways and address these challenges, improving experience for patients. However, doing so will require investment of time and effort by ICBs. NHS England should consider opportunities to provide ICBs' increased capacity to lead dentistry transformation.
- 5. Dentistry contract.** There is variation between ICBs on the extent to which they feel they can exercise flexibility within the existing dentistry contract to drive improvement. An effective feedback loop between systems, regions and the centre can identify and address barriers to transformation. NHS England should set up a working group with ICBs and NHS regional teams to improve understanding of what flexibilities already exist within the dentistry contract and where flexibility may be required.

Annex: POD commissioning roles and responsibilities under delegation

National	Regional	ICS/ICB
National contract negotiations.	Accountability for overall delivery of services.	From April 23, take on delegated responsibility for commissioning of POD services.
Oversight of primary care financial allocations.	Oversight of POD commissioned services, promote transformation, improvement and provide assurance.	Liability for the commissioning and effective delivery of POD services.
Development of national programmes in support of NHS LTP and other national programmes/initiatives.	Retain regional finance and clinical oversight and capability.	Employment of staff who carry out commissioning functions.
Review and update policy guidance.	Assist in development of integrated care models.	Assess needs, plan and arrange services taking consideration of financial obligations and patient choice.
Policy, support and governance of decisions, relating to performers list management and responding to performer concerns.	Assist in advancing health inequalities agenda.	Integration of POD commissioning within wider commissioning services at ICB level.
Management of FOI, PQs, media enquiries in respect of national policy.	Support capability and capacity building in ICB-led commissioning.	Advance personalised care agenda.
Distribute national pilot funding.	Transformation and improvement support to commissioned services.	Ensure quality and assurance processes are embedded in all activity.
		Work across ICBs to drive integration of services and local decision making.

Source: NHS England toolkit

References

1. Cubbon, M. (2022). Delegation of NHS England’s direct commissioning functions to integrated care boards. <https://www.england.nhs.uk/wp-content/uploads/2022/05/PAR1440-letter-roadmap-for-all-direct-commissioning-functions-may-2022.pdf> (accessed on 8 March 2023).
2. Dr Fuller, C. (2022). Next steps for integrating primary care: Fuller stocktake report. <https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/> (accessed on 8 March 2023).
3. NHS England (2022). Community Pharmacy National Enhanced Service COVID-19 vaccination programme: September 2022 to March 2023 (phase 5). <https://www.england.nhs.uk/coronavirus/documents/community-pharmacy-national-enhanced-service-covid-19-vaccination-programme-september-2022-to-march-2023-phase-5/> (accessed on 8 February 2023).
4. UK Government (2022). Health and Care Act 2022 – Schedule 3. <https://www.legislation.gov.uk/ukpga/2022/31/schedule/3/enacted> (accessed on 21 February 2023)
5. Pritchard, A. (2021). NHS England and NHS Improvement’s direct commissioning functions. <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2021/07/PAR817-NHS-England-and-NHS-Improvements-direct-commissioning-functions.pdf> (accessed on 9 February 2023)

6. NHS England (2022). Primary care commissioning assurance framework 2022/23. <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2023/01/Primary-care-commissioning-assurance-framework.pdf> (accessed on 9 February 2023)
7. NHS England (2023). Delegation of primary medical, pharmaceutical, ophthalmic and dental functions. <https://www.england.nhs.uk/commissioning/publication/delegation-of-primary-medical-dental-ophthalmic-and-pharmaceutical-functions/#heading-1> (accessed on 9 February 2023)
8. Department of Health and Social Care (2023). Dental contract reform: a report on learnings from the dental contract prototype test between April 2016 and March 2019. <https://www.gov.uk/government/publications/dental-contract-reform-evaluating-the-results-of-the-prototype-scheme/dental-contract-reform-a-report-on-learnings-from-the-dental-contract-prototype-test-between-april-2016-and-march-2019#conclusions> (accessed on 7 February 2023)
9. Anderson, H. (2023). ‘NHSE set for £400m dentistry underspend despite ‘access crisis’’. HSJ, 21 February 2023.
10. Healthwatch (2022). Lack of NHS dental appointments widens health inequalities. <https://www.healthwatch.co.uk/news/2022-05-09/lack-nhs-dental-appointments-widens-health-inequalities> (accessed on 7 February 2023).
11. Department of Health and Social Care (2021). Pharmaceutical needs assessments information pack for local authority health and wellbeing boards. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1029805/pharmaceutical-needs-assessment-information-pack.pdf (accessed on 11 February 2023).

12. Public Health England (2021). Inequalities in oral health in England: summary. <https://www.gov.uk/government/publications/inequalities-in-oral-health-in-england/inequalities-in-oral-health-in-england-summary> (accessed on 11 February 2023).
13. NHS Clinical Commissioners (2022). Clinical commissioning groups: transferring the legacy into learning. <https://www.nhsconfed.org/publications/clinical-commissioning-groups> (accessed on 11 February 2023).
14. NHS England (2023). Integrated care board running cost allowances: efficiency requirements. <https://www.england.nhs.uk/long-read/integrated-care-board-running-cost-allowances-efficiency-requirements/> (accessed 8 March 2023).
15. Cubbon, M., Sloman, D., Kelly, J. (2023). Direct commissioning delegation. <https://www.england.nhs.uk/wp-content/uploads/2023/01/PRN00089-direct-commissioning-delegation-letter-jan-23.pdf> (accessed on 8 March 2023).
16. Sparke, A., Hurley, S. (2022). Outcome of 2022/23 Dental contract negotiations. https://www.england.nhs.uk/wp-content/uploads/2022/07/B1802_First-stage-of-dental-reform-letter_190722.pdf (accessed 8 March 2023).
17. Mortimer, D. (2022). An NHS workforce plan that is fit for the future is needed to give staff hope. <https://www.nhsconfed.org/articles/nhs-workforce-plan-fit-future-needed-give-staff-hope> (accessed on 11 February 2023).

18. Office for Health Improvement and Disparities (2022). The impact of COVID-19 on access to dental care: a report from the 2021 Adult Oral Health Survey. <https://www.gov.uk/government/statistics/the-impact-of-covid-19-on-access-to-dental-care/the-impact-of-covid-19-on-access-to-dental-care-a-report-from-the-2021-adult-oral-health-survey> (accessed on 8 February 2023).
19. Public Health England (2021). Inequalities in oral health in England, available at: <https://www.gov.uk/government/publications/inequalities-in-oral-health-in-england/inequalities-in-oral-health-in-england-summary> (accessed on 8 February 2023).
20. Healthwatch (2022), Our position on NHS dentistry, 12 October 2022. <https://www.healthwatch.co.uk/news/2022-10-12/our-position-nhs-dentistry> (accessed on 9 March 2023).

18 Smith Square
Westminster
London SW1P 3HZ

020 7799 6666
www.nhsconfed.org
@NHSConfed

If you require this publication in an alternative format,
please email enquiries@nhsconfed.org

© NHS Confederation 2023. You may copy or distribute this work, but
you must give the author credit, you may not use it for commercial
purposes, and you may not alter, transform or build upon this work.

Registered charity no. 1090329

