

# The role of primary care in integrated care systems



## **About the NHS Confederation**

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks and federations, clinical commissioning groups and integrated care systems.

We are committed to providing a strong national voice for primary care. Our PCN Network represents, connects and supports primary care networks across England, and our Primary Care Federation Network provides dedicated support to GP federations.

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# Key points

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- This report sets out the views of our primary care members on the underpinning principles needed for strong primary care involvement at system and place.
- Overall, our members welcome the direction of travel signalled in the government's white paper on health and care reform in England. However, over 50 per cent of primary care leaders and managers surveyed for this report stated that they were 'unclear' or 'very unclear' about the role of primary care networks within integrated care systems.
- Many of the proposals have the potential to bring the healthcare system closer to being truly population health focused and reflective of local need. However, this will only be achieved with ongoing and meaningful engagement with primary care and adequate resourcing of primary care leadership.
- Our members have set out five key requirements they want to see in the development of ICS structures, governance and, most importantly, culture. This includes: collective voice and representation for primary care at system level; processes and structures for primary care at place level; system priorities that reflect local neighbourhood needs; systems that promote collaboration and enablers that equip primary care for system working.
- We look forward to seeing these reflected in national guidance for systems, and working with NHS England and NHS Improvement to showcase examples of good practice.

# Background

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Following publication of the government's [white paper](#), Integration and Innovation: Working Together to Improve Health and Social Care for All, the NHS Confederation held a series of engagement sessions with its PCN Network and Primary Care Federation Network members. The sessions gathered views on the role of primary care in integrated care systems (ICSs) and what would be required for primary care to engage effectively in system working.

We sought to understand members' views on the role of primary care as set out in the white paper and identify what additional guidance and support is needed to be successful. Despite workload pressures on primary care, the enthusiasm from clinical and non-clinical leaders to participate positively and productively was overwhelming, demonstrating their desire to have a meaningful voice in the system and work collaboratively to achieve the ambitions of the white paper.

## Approach

We conducted engagement sessions with primary care networks (PCNs) and GP federations during February and March 2021, and surveyed more than 200 participants from primary care, including PCN clinical directors, PCN managers and senior leaders from across GP federations. A number of those who took part in the engagement either already had a role in their local place and/or system and were able to draw on their own experience. We asked three questions during our engagement sessions:

- What should be the role of primary care in achieving the objectives of ICSs?
- What does good engagement look like at place and system levels?
- What is required to enable effective engagement at place and system levels?

# Key requirements

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The five key requirements in this paper reflect what our members want to see in the development of ICS structures, governance and, most importantly, culture.

## 1. Collective voice and representation for primary care at system level

A strong voice for primary care at system level, which is representative of all its parts, is essential if system objectives are to be underpinned by knowledge of local communities.

Enabling a collective voice for primary care will help remove many of the barriers to engagement and collaboration caused by the perceived complexity of the primary care system. It will facilitate improved representation, a shared vision and a focus on population health management at neighbourhood and place levels. There are already many examples of governance arrangements that have been established with a clear 'golden thread' from primary care through place to system level, enabling all parts of primary care to contribute. We heard from PCNs in Greater Manchester that have developed arrangements that establish this line of accountability, and PCNs in other areas which have formed place-level primary care provider boards to address this issue.

In [Legislating on the Future of Health and Care](#), the NHS Confederation has already argued that any statutory requirements or guidance on primary care representation at system level should be flexible, recognising that primary care is more than general practice. For example, in Bedfordshire, Luton and Milton Keynes ICS, a partnership board has developed, which will transition into the ICS board. It includes primary care representatives from each of the ICS' four places that are drawn from PCNs and are not required to be clinical directors.

In addition to this, guidance will need to do more to prevent a tokenistic offer of representation and instead show an understanding of what primary care offers the system. We need to create an expectation on systems so primary care is represented fairly and equally in discussions, decisions, partnerships and governance structures at all levels as ICSs develop. Our survey showed that just over 12 per cent of those who responded are always involved in discussions at system level.

One way to achieve this is through engaging with newly emerging groups of primary care providers that encompass all primary care, not just general practice. NHS England and NHS Improvement should ensure that future guidance recognises the role and value of these ‘at scale’ collaborations in providing a collective voice for primary care and enabling strong representation at system level. Where these do not currently exist, national guidance should set out requirements for systems to support their establishment.

The recognition of the need for clinical leadership throughout systems is paramount. We support the prioritisation of clinical involvement in the ICS as a measure of success and this will go some way to ensuring systems are not only accountable to management structures and leadership, but to patients and staff.

“80 per cent of what primary care does is the same across systems – the 20 per cent allows them to be locally intelligence driven, and this is vital. But the 80 per cent means that there is the ability for ‘team primary care’ guidance and legislation.”

## 2. Processes and structures for primary care at place level

To enable primary care to engage effectively at a system level, we also need strong and inclusive governance at place. Although the intended flexibility to develop place-level arrangements is welcome, we would like to see clear requirements set out to ensure ICSs deliver on their objectives and avoid the risk of being lost with the transition to system working:

- **Infrastructure support for primary care to enable links into the wider NHS** – currently a lot of this support is provided by clinical commissioning groups (CCGs) and there is a risk this will be lost with the move to ICSs. In some areas of the country, this support is already being commissioned from primary care federations. These services range from financial management through to employment and administrative support, with some existing organisations, such as Alliance for Better Care GP Federation in Surrey providing communications support to PCNs.
- **Facilitation of partnership-working** – brokering conversations between primary care and other parts of the NHS as well as local authorities and the voluntary sector, to enable the development of integrated pathways supported by a flexible workforce. The vaccination programme is the most recent example of GP federations supporting these conversations at place and delivering on behalf of primary care. However, they were already taking place: Manchester Primary Care Partnership, for example, supported GP practices when the Homelessness Access Hub project was commissioned.

There is a clear need from primary care to have clarity on the functions, accountabilities and interrelationships of existing arrangements. This includes vertically from system to place to neighbourhood, as well as horizontally to other system partners (including health and wellbeing boards (HWB), provider collaboratives and integrated care partnerships (ICPs)). This will enable primary care to have a better understanding of the system, its constituent parts and enable it to understand its role. These could provide routes for primary care involvement, particularly on HWB boards, enabling primary care to shape strategy at place level and ensure overall ICS accountability.

With some members already developing their own place-level arrangements and 30 per cent of survey respondents 'often involved' in discussions at place level, the permissive approach is valued.

**“If we shift many of the functions of a CCG up to ICS level, there is a risk that the ICS will be too big to be able to replicate those functions. There will need to be agencies that can fulfil those roles at a place-based level.”**

**“It’s important some of the power remains at place, where we know our communities.”**

### **3. System priorities that reflect local neighbourhood needs**

The proposals place commissioning functions at ICS level, far away from the communities they serve. This risks decisions being made at a system level that do not reflect the needs of all communities at neighbourhood, or even place, level. ICSs must therefore develop mechanisms to ensure sensitivity to population health needs at all levels, for both commissioning and service provision.

For commissioning, this entails PCNs understanding their communities. This requires being resourced to engage communities in co-design and co-production, as well as to gather population health intelligence through fit-for-purpose infrastructure and access to wider datasets, such as the Census, Acorn and local authority data. The vaccination programme has been an opportunity for PCNs to engage with their communities, with conversations taking place with faith leaders regarding co-design of mental health services in Surrey Heartlands ICS, for instance. Furthermore, leadership skills for PCN staff will also need to be developed, both to enable them to take active roles in their communities and to advocate for their communities on any boards, in particular the ICS NHS board.

Service provision must also take place at the appropriate level for the population served. This involves clarifying the roles of provider collaboratives and ICPs, as well as ensuring funding is available for GP federations providing or involved in 'at scale' services across primary, community and secondary care. For example, Connexus GP Federation in Wakefield helped create a service specification for a single primary care provider to deliver lung health checks across three GP practices with the highest smoking rates, as part of West Yorkshire and Harrogate Cancer Alliance.

Governance arrangements must also be in place that provide a line of accountability to system level to ensure community views and neighbourhood population health intelligence influence ICS strategy and commissioning decisions. Decisions must also be made in line with the principle of subsidiarity, with transparency of decision-making at every level possible, information in the public domain and public consultation on the health and care partnership's plans. Furthermore, clarifying its relationship with the ICS NHS board and HWBs could provide a route for subsidiarity and accountability. Additionally, placing responsibilities on the ICS NHS board through Memoranda of Understanding would ensure it is sensitive to local, neighbourhood needs.

Given the ambitious timescale involved in the reform, there is also a risk that the focus will be on structures and processes rather than health outcomes. It is therefore vital that systems are built from the grassroots level from the outset, ensuring that accountability from neighbourhood to system level is easier to manage.

**“Throughout my whole career I have been trying to find a way to influence healthcare from the ground up. We have been promised it over the years several times, but this has never really happened, but this feels like an opportunity for us to lead from the grassroots.”**

**“This is an opportunity for us to think about the functions of ICSs and how we ensure the clinical outcomes and health inequalities that the last 12 months have highlighted are really at the centre of ICSs, so we don't waste too much time thinking about structures but make sure that they're right from the beginning.”**

**“We need to think about how we ensure ICSs have enough flexibility so we don't impose one answer and solution on every community and neighbourhood within a system.”**



## 4. Systems that promote collaboration

Effective system working requires collaboration from all partners. This can be achieved through a focus on objectives, including bolstering the duty to collaborate, understanding how incentives drive activity, and adopting a permissive approach.

The vaccination programme demonstrates what can be achieved through collaboration and, as a result, partnership working within systems. For primary care, the ability to come together for a common purpose underpins the success of the programme, with many 'vaccination programme boards' having been set up across system partners and vaccination centres making best use of idle premises across systems. Importantly, this collaboration occurred organically, with different arrangements being adopted in each system as well as different models at neighbourhood and place levels within systems themselves. However, this is not a uniform picture – less mature systems affect the ability for partners within the system to collaborate effectively.

As systems develop, collaboration can be translated into both ICS architecture and working practices through bolstering the duty to collaborate. As set out in the NHS Confederation [report](#), the duty to collaborate on improving health inequalities could create a shared vision for each system, which would inform the priorities for the system and between system partners. Primary care has a strong appetite to embed system objectives that reflect neighbourhood need within all aspects of its own work.

Collaboration can be further engineered into working practices through incentives that motivate the appropriate system partners. For primary care, both the Quality and Outcomes Framework (QOF) and the Investment and Impact Fund (IIF) are a step in the right direction, but they need to be adapted to incentivise the right behaviours and reflect the differing needs of individual communities. There needs to be greater flexibility within the IIF to enable primary care to focus on those outcomes that will have the biggest impact on patient outcomes and reducing health inequalities.

**“New collaboration has happened through COVID-19 where the engagement has been about trying to effectively commission an outcome.”**

**“It would be good if people carried on being collaborative and helping each other.”**

## 5. Enablers

For primary care to fully engage in system working, they must be enabled to do so, and in a way that is not detrimental to its core activity. This requires three key enablers, which together create the ability for primary care to play a key role.

### a. Invest in primary care leadership capacity

Engagement in ICSs requires primary care leaders to take on additional work to their core activity. Results from our survey showed that 20 per cent of primary care leaders cited insufficient time as a barrier to effective system engagement.

While a number of PCN clinical directors and GP federation leaders are already engaged in work at system and place, this has often come with additional funding from the system. Equally, the additional funding to clinical directors during COVID-19 has significantly helped with collaborative working and system engagement on the vaccination programme. This demonstrates what can be achieved when resources are invested to support leaders to engage in the system. Additional funding needs to be provided to enable PCN clinical directors and other primary care leaders to dedicate time for system leadership.

**“How do we level up and represent at those meetings? This will, of course, pull away from clinical time.”**

**“We have been uplifted to one whole-time equivalent. In truth, I’m now being paid to do the work I have been doing for the last two years.”**

### b. Invest in primary care leadership capability

In many instances, primary care leaders will need to be supported to develop the leadership skills necessary to take a key role in place and system. Much of this support is currently provided by CCGs or systems, where primary care is already an integral part. A real focus on primary care leadership needs to be part of the organisational development programme for systems. Current CCG funding that is in place to support PCN leadership development could be: transferred into primary care budgets; devolved to GP federations where they exist and are supporting PCNs; or channeled into PCN development funding to support this work.

**“How do we, as PCNs, have that level of influence, sitting at a table with chief executives of large foundation trusts?”**

### c. Financial certainty

The move to ICSs comes with uncertainty and perceived financial risk for primary care providers, especially for general practice. This is exacerbated by the need for ongoing investment in the NHS and public health budgets to alleviate competition for resources between providers. The lack of clarity surrounding contractual arrangements beyond 2024 and the move to commissioning at ICS level is leading to apprehension regarding future funding for primary care.

To ensure the sustainability of system working, a long-term recognition of secure funding streams needs to be identified. The loss of a separate commissioning organisation, whereby commissioning functions are delivered by the ICS NHS board that includes providers from across the system, with only one representative from primary care, risks the acute voice and financial demands dominating the agenda. This could risk funding shifting from primary care to secondary care to address short-term pressures.

To remedy this, firstly, strong representation of primary care on the ICS NHS board would ensure the voice of the sector is heard. Secondly, clarification surrounding the decisions that can be delegated to joint committees, and the process for doing so, should be provided to clarify the potential place-level commissioning decisions. Thirdly, primary care funding needs to be ring-fenced beyond the current five-year allocation.

“If we are not round that table, we do not get a slice of the pie.”

# Next steps

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Our engagement has shown a real desire from primary care leaders to have a meaningful role in their system and place. But we need to recognise the context within which they are working and the challenge of freeing up time to play a meaningful role. They must be supported if the health and care sector is serious about system working, collaboration and focusing on the needs of local communities.

We will continue to work in partnership with NHS England and NHS Improvement and the government to ensure the voice of primary care is heard and their role in systems is clear and widely understood.

## Contact us

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