

# Working with the New NHS Structures

## Exercising the General Practice Voice within CCGs, ICPs within Integrated Care Systems

## Introduction

The internal structures of the NHS are fundamentally changing, driven by the Government's integration and efficiency agendas. It is a common belief that the fragmentation of the NHS has not served patient care well and leads to significant delays, transaction costs and inefficiencies. Whilst there might be truth in this, the drive to get the most out of the NHS pound may well undermine efforts to truly integrate services and improve patient care.

We now have Integrated Care Systems (ICSs), Integrated Care Partnerships (ICPs), Clinical Commissioning Groups (CCGs) and Primary Care Networks (PCNs). Of these only CCGs are legal entities at this moment in time and we have a parallel universe of Acute Trusts, Community and Mental Health Trusts, NHS England (NHSE) and GP practices, all tied together within contractual frameworks. At a further distance we have Social Services and other commissioned Local Authority (LA) services and the myriad of Third Sector providers of all sizes and types – some of whom we may not know anything about.

Around the UK statutory bodies are working out what they will do at a Regional Level (the ICS) and what will be the responsibility of the local (Placed Based) Integrated Care Partnership. All are at different stages and it is difficult to have any confidence that something consistent will emerge that is not tainted by local power politics and personalities. Most of these structures have been around, with a succession of names for around three years or more now but have not yet emerged as a credible force for change that is impacting on improved patient care.

In Cheshire most discussions have been high level, about strategic intent, vision, values and governance with high levels of external communications activity and an obsession with 'relationship structure' and bureaucracy. Our CCG's fundamental role of commissioning, what it means and where it will sit, is being questioned with not many clear answers emerging to date. We are seeing CCG staff 'aligned' to ICPs but who will do what and its funding relevance to GP practice is still unclear

It is commonly recognised that the tactical commissioning function can more easily sit as part of a provider function and that the new "systems," be they at neighbourhood or care community level will involve detailed discussion on pathway design, resource utilisation and implementation between providers in partnership. The strategic commissioning function will remain but at a higher (NHSE and CCG) level and not be involved in detailed planning work.

Primary Care Networks arrived a little late on the scene in the 2019/20 GMS contract negotiations. We had been preparing our practices for general practice at scale working but had had very little by way of invitations from the ICP 'partners' to get involved in wider discussions. These PCNs are not legal entities, but a collection of practices held together in a (limited at present) collaborative arrangement through an "at scale" Directed Enhanced Service (DES) as part of the GMS contract. The requirements of these PCNs, through the DES, are limited in 2019, but will increase in year 2 (2020) and year 3 (2021). Expectations of the PCNs are huge (and it feels getting bigger), only matched by the corresponding lack of infrastructure and time to enable their success.

## General Practice Voice(s)

All within general practice would agree that it is vitally important that the voice of general practice is clearly heard in the planning and delivery of health care. GPs are still the gatekeepers of the NHS, deciding who and when to refer on to specialist or other care services; however, we are struggling to control the gate which now seems to be swinging in the other direction, from specialist to primary care.

The argument for primary care involvement seems to have been won on a national basis but we are not convinced it has been accepted, or even acknowledged, by some of our secondary care colleagues. Despite years and years of resources pouring into secondary care at the expense of primary care, some secondary care colleagues are now complaining that some resource is now flowing into primary care and are pressurising for “results” that alleviate secondary care problems. It is our understanding that the recent contract agreement was to stabilise general practice to do what it does currently rather than fund a wholesale shift of activity from secondary or Local Authority care.

As the governance structures of integrated care are developed there are calls for GP involvement at each level of the new structures. PCNs, as the ‘new kids on the block’, are being requested to have a presence at an ever growing number of meetings. The desire for GP representation is however seldom matched with a willingness to fund such representation.

Against this background it might be appropriate for the LMC (possibly with PCN input) to consider undertaking a review of the level of representation that can be reasonably expected from the funding available. As part of this exercise it needs to be recognised that there are only so many GP leaders / representatives to go around and we need to be clear about who we ask to be involved in what. As a starting point we might identify a number of distinct GP Voices.

### The GP Commissioning Voice

Our four original CCGs appointed Clinical Directors who have built up a wealth of knowledge around the development of clinical strategy and the commissioning of health care across primary and secondary care. They are a valuable source of commissioning knowledge and experience that needs to be maintained as CCG numbers and influence diminishes. As the CCGs merge in April 2020 some of these colleagues will be displaced by this exercise. We should consider (with the CCG?) how we keep this level of experience locally.

### The Expert GP Voice

In many instances CCGs have appointed clinical leads to steer pathway development work in specific disease areas such as mental health, diabetes, CHD and Cancer. These “expert” advisors have a place in advising on the design of specific pathways and could be commissioned as such. There is however always a danger that these GPs, with particular knowledge or special interest, design services around their competence and passions rather than those of the average working GP who we represent.

### The Representative GP Voice

There has been a strong tradition of individual GPs exercising their voice through a collective mechanism as there is no equivalent line management structure to that found in other statutory organisations. There is very rarely one voice of general practice, and the LMC, as the organisation recognised under NHS Acts, has to work hard to hear the range of opinions expressed and try to put forward a balanced and reasonable view of the collective GP view.

LMCs have been in existence since 1913 and so have some system continuity and gravitas in terms of both being a member organisation and one which can help unite the common aspects of the GP voice. It does this from the point of being a professional representative body made up of largely elected members which cover all GPs under whichever contract status they have.

They also have access to a wide range of national expert and advisory groups on which they can draw in providing system and subject advice.

### The PCN Clinical Director Voice

AS PCNs are seen as the first tier of integrated working there is a requirement that PCN Clinical Directors get involved in decision making in the newly emerging ICP and ICS arrangements. The DES states:

*“The Clinical Director will work collaboratively with CDs from other PCNs within the ICS / ICP Area, playing a critical role in shaping and supporting their ICS / ICP, helping to ensure full engagement of primary care in developing and implementing local system plans.”*

Within their key responsibilities there is specific reference to their representative function:

*“They will represent the PCN at CCG level clinical meetings and the ICS / ICP, contributing to the strategy and wider work of the ICS / ICP”*

We may need to explore the PCN role in more detail later in this paper but one suggest might be that the PCN CD voice will replace the CCG Clinical Director voice in pathway and system design.

### The Layers of the New NHS Architecture

It is common in describing NHS structures to start at the top and work down. However, for the purposes of this paper I suggest it is more important to start at the bottom and work up. After all it is seen as good practice and we are encouraged to take a bottom up approach.

#### The Individual GP Voice (around 530 partners and salaried; almost 630 in total)

The fundamental interaction between a patient and the NHS is through an individual clinician, be they a GP, Consultant, Nurse or other health professional. It is at this level that the patient forms their basic conclusions as to how the health service has worked for them.

In turn the GP or clinician needs to feel competent, informed and supported in their front-line interactions. Too often we hear of GPs feeling overworked and stressed with systems that don't work for them. They need to feel supported and valued by their organisations for which they work. This has major implications in terms of communications, culture and organisational development within and between organisations. Functions and pathways need to be clear as do relationships between the various elements of health care and beyond.

The GPs role, as a coordinator of care, Multi Disciplinary Team member or system leader needs to be recognised and supported in terms of development, time available and funding.

#### The Practice Voice (81 in Cheshire reducing to 79 in the New Year)

***“General Practice is the bedrock of the NHS and the NHS relies on it to survive and thrive.”***  
***Opening Statement of the Investment and Evolution 5 year GP Contract reform January 2109)***

The GP Practice remains the basic building block of primary and community care, with the vast majority of primary care contacts taking place within individual practices. We believe that this will continue. It is at this level that a team of GPs, some partners and some salaried, offer

comprehensive continuity of care “from cradle to grave,” supported by the core and extended primary health team. The additional roles funded through the PCN Network DES support the expansion of this. As an LMC we see the concept of the practice and the partnership model as being key to the success of the UK health care system.

The GP Partnership Review, Chaired by Nigel Watson, published in 2019, reinforced the importance of the partnership model, based in practices, to the success of primary care. This was further enhanced when Primary Care Networks were announced in the GP Contract Reforms (April 2019), comprising a collaboration of practices within a natural community.

### The Primary Care Network (18 in Cheshire)

There has always been recognition within primary care of the importance of joined up care, but previous NHS reforms seemed to compromise this principle. More recently a series of academic papers have been coming out from such bodies as the Kings Fund and RCGP advocating a model of integrated neighbourhood provision with a greater emphasis on prevention, holistic care and patient or community empowerment. The Primary Care Home (such as the model in Winsford) initiative championed by NAPC built on this work.

The NHS Long Term Plan, published in January 2019, picked up this concept and linked it to the growing “*multiple challenges – with insufficient staff and capacity to meet rising patient need and complexity.*” (para 1.5) The aim was to “*finally dissolve the historic divide between primary and community health services*” and invest substantial money to “*boost out of hospital care.*”

The answer within the Long Term Plan was to create expanded community multi-disciplinary teams aligned with new primary care networks based on neighbouring GP practices. The full range of community staff, social work and voluntary sector would be aligned to the network footprint (para 1.9)

The importance of Primary Care Networks is reiterated in the Investment and Evolution 5 Year Contract Reform, saying “*Primary Care Networks are an essential building block of every Integrated Care System,*” with “*general practice taking the leading role in every PCN*”

It is still very early days for PCNs with an evolutionary process towards greater levels of responsibility as experience, development and resources allow. At the moment most are concentrating on internal relationship building between practices and haven’t yet cemented the links to the wider community staff groups as envisaged in the Long Term Plan.

The nature of PCNs is somewhat confusing. They are not legal entities in themselves but may have some element of legal structure around them. Each must appoint a Clinical Director but their accountability is to the PCN members (para 4.4.2 – Network Contract DES) There is no specified accountability upwards. The legal framework within which the PCN core members operate is by signing up to the Network DES, an extension of the core GMS contract. In turn there are requirements within the Network DES agreement regarding the core membership and how they work collectively. There are also stipulations within the Standard NHS Contract placing a duty of engagement and cooperation by community providers.

It is very clear that there is a massive operational agenda in managing, planning and delivering community and primary care services, linking in with social and voluntary sector providers. It is also abundantly clear that there is no infrastructure or planned infrastructure to allow this to happen. So whilst GPs are nominally in charge they may not have the tools or the time to do the job.

This operational agenda gets even more challenging in the new year (2020) when the seven service specifications are published (draft issued December) as an extension to the Network DES and more “Additional Roles” are released. At the same time a dashboard is introduced with an opportunity for PCNs to earn extra resource through the Impact and Investment Fund (IIF). Then there is the aspiration to undertake population health management which will bring a whole new level of complexity, analysis and management into primary care.

Over and above this operational management challenge there is an expectation that PCNs, through their Clinical Director and acting collectively with other PCN CDs will play a critical role in shaping and supporting their ICP (and ICS) helping to ensure full engagement of primary care in developing and implementing local system plans. (para 4.4.2.c)

So what is the priority of the PCN? Is it -

- to coordinate and manage a comprehensive and diverse integrated care team at neighbourhood level and, if so, with what powers and accountability?
- Is it one piece of a jigsaw of PCNs each making up the total ICP community and primary care delivery model and, at the same time, agreeing the boundaries, responsibilities and resources with secondary care.

Of course, not all primary and community services need to be provided on the footprint of each PCN and there are some more specialised services that are more logically provided on a health community footprint. The community health crisis response and re-enablement services, as described in the Long Term Plan (para 1.8) are such services. How are these to be agreed and managed, would it be through a collective PCN arrangement, through a lead PCN model or through a separately managed service?

As ever the interface between all components of the system will need to be clear, agreed and effectively managed.

This outline of the roles and responsibilities of PCNs is meant to inform thinking on how they should be involved in wider system planning. Are they doing this as GPs, commenting on pathway development (would an expert lead be best at this); or as the lead of an organisation carrying out a defined range of services in the neighbourhood?

How does this relate to the role of the LMC that is representing the interests of individual practices regarding workload, resources and workforce? Do all PCN CDs need to be at the ICP Board and its associated governance arrangements or could one represent all PCNs. If so, how could this representation be coordinated to get a mandate from all PCNs? Is the number of PCN CDs there important to balance the potential to be outgunned by a whole team from the Acute Trust; and does it need to be a CD that sits at the table or could it be a ‘strategic manager’?

### **The Integrated Care Partnership (East and West Cheshire ICPs locally)**

This organisational level is based on acute hospital catchment areas which, to some extent do reflect natural communities. It is at this level that the full range of general health and care services (i.e. not specialised regional services) are available for a population. Largely they coincide with local government and third sector footprints.

Therefore the ICP is where all the organisations providing health and care services naturally meet to assess their health and care needs, assess priorities and plan the delivery of services to meet needs. In doing so they need to effectively manage the interface between their respective services.

Functions of the ICP (adapted from a Kings Fund publication - Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England – 2108) are as follows:

- agree a performance contract with the ICS to deliver faster improvements in care and shared performance goals
- manage funding for a defined population by taking responsibility for a system 'control total'
- create effective collective decision-making and governance structures aligned with accountabilities of constituent bodies
- demonstrate how provider organisations would operate on a horizontally and vertically integrated basis,
- deploy rigorous and validated population health management capabilities to improve prevention, manage avoidable demand and reduce unwarranted variations
- establish clear mechanisms by which residents can exercise patient choice over where they are treated.

Some ICPs are starting down the road of having common support functions for all constituent organisations, such as strategic planning, finance, IT & information services, service redesign, HR, and communications. The impact of such common service departments on general practice remains to be seen. Is it better to have support from an organisation familiar with primary care, or will integrating these services help improve understanding across all sectors of health care?

What is becoming a (worrying) trend is that the service response to such complexities is to set up more working groups, committees and sub committees to meet their perceived governance requirements. Such arrangements can demand a high level of GP involvement in the various groups and committees. Whilst general practice needs to have a voice, do we respond blindly to all requests (whether or not funded) or do we need to be selective in what we sit on?

An area alluded to previously in this paper was the place and role of commissioning. Some CCGs may wish to have a presence within ICPs (perhaps as standing invite to attend or as observers) but is this a commissioning role or is the CCG role better defined as strategic planning. The design of health care pathways, interfaces and desired outcomes are surely the province of clinicians and associated service managers.

A key question is how GPs are organised within an ICP. Has this been answered by the creation of PCNs, preserving the partnership model by practices working collaboratively across a neighbourhood? Are PCNs the voice of general practice, or the voice of care communities, that just happen to be led by GPs? Does the LMC have a representative role at the top table of the ICP Board even though it in itself is not a provider organisation? Or does the LMC have some other external role in ICP plans?

A challenge for ICP governance arrangements is the disperse nature of general practice. Most organisations have a clear organisational structure through to a Chief or Accountable Executive who, in theory, can commit their organisation to a certain course of action. That is not the case in general practice where there needs to be engagement and discussion across all practices before a commitment can be made. NHS Trusts and other providers struggle with this concept and would dearly love to see a 'GP Provider Chief Executive'. What about GP Federations which are provider bodies? In other parts of the UK some emerging ICPs have considered the role of the GP Federation

and the idea of a Federation Chief Executive, but we would question whether a GP Federation has a mandate to commit all practices, or just those areas that the Federation manages “at scale.”

In a similar vein the draft Multispecialty Community Provider contract sets out three models of primary care engagement:

- a virtual MCP where practice signed up to a collaborative approach to partnership with other health service providers
- A half way house model where practices kept their core GP contract, but all other enhanced services and services at scale were stripped out to be ran and managed centrally
- A full integrated model where all GPs became salaried, practice premises came under the ownership of an umbrella organisation and all staff were employed by the same organisation.

These options seemed to be shelved in the light of challenge, but will they re-emerge in the light of the comfortable majority that the government now has. It can be expected that legislation will soon emerge to dismantle the 2012 Health & Social Care Act to pave the way for the force the merger of CCGs (might we even see the demise of CCGs?) and provide a legislative basis for ICPs and ICSs.

### The Integrated Care System (Cheshire approx. 1m population - Cheshire/Merseyside 2.1m population)

The ICS operates at a level above the ICPs with a population of 1.5m plus. It is the new system driver for NHS reform and will be held to account for total system performance at a regional level by NHSE (now NHSE/I as NHS Improvement which was Monitor now combined with NHSE). In turn it will hold ICPs to account for their performance. In effect they will be the ‘regional police force’ of the NHS on behalf of central government.

In previous years such a role was carried out by Regional Health Authorities and then Strategic Health Authorities. The functions that will be carried out at this level are being developed, but will include strategic planning and commissioning, strategic resource allocation and overseeing implementation of the NHS Long Term Plan by performance managing ICPs.

There are certain functions that make sense being managed at this level, including rationalisation of acute services and regional specialist services. There is also the concept of doing things once that only need to be done once and providing frameworks for initiatives that need to be tailored for local implementation in each ICP. Some primary care contracting and ‘Quality Contracts’ may fit into this category instead of the current situation where each CCG reinvents its own quality contract.

What then is the need for the GP voice at this level? In terms of the ‘big picture’ strategic planning and acute service rationalisation we would argue that it is less important than involvement at ICP level. There does need to be GP advice and maybe this is best provided through whatever replaces CCG Clinical Directors. We do not think it is the remit of PCN Clinical Directors, but they do have a role in shaping integrated care planning should such a role have a function at ICS level.

If CCGs ever did disappear over time then there is a possibility ICSs (or ICPs) might hold the GP contract. If ICSs ever do hold the GP Contract and design any Quality Contracts, then appropriate representation will be required. We would suggest this is an LMC role and there may be a need for LMCs to be reconfigured to match any new statutory body footprints.

We also need to take note of the role of the none statutory Sustainability and Transformation Plans (renamed as Cheshire and Merseyside Health & Social Care Partnership Board for our area). These



'structures' have developed since 2016 but despite a focus on local collaboration by, in particular, secondary care leaders, key elements of their plans have in fact been top down driven i.e. NHSE/Dept. of Health in terms of improving both health and social care outcomes. They have access to significant funding and so we need to work with local partners including the CCG and ICPs to access these infrastructure support funds. At present the STP seems to focus working with GP Federations (it is understood there is a single GP rep invited to meetings but this may change).

STPs often are seen as part of mechanisms to reduce the cost of health and social care services in financial terms using 'integration' as a byword for such efficiencies to be delivered.

One of the key issues we have not really see articulated in any of the papers describing the above architecture is 'accountability', but it is vitally important. In practice without an underpinning legal entity it is impossible for a partnership of any kind to accept clinical/financial/legal accountability for populations and individuals that require an integrated, shared approach between the wider member bodies. Perhaps a new Health Bill will mandate this.

## Where Next?

There are real wider challenges in making progress for the benefit of general practice.

- One potential barrier to integration is the different system regulators (including NHSE/I and CQC) who need to change the way they work to support the Governments ambitions for integration and better inter organisational working. This needs to be addressed centrally or even better by current local system leaders.
- Linked to this is the risk that the regulators behaviour will undermine moves in local systems to work together. This may then result in top down performance management approaches which will limit innovation and real change. It will also limit ICPs/ICSs taking a lead.
- It will be important to engage with the wider system organisations. Local Authorities in particular (but third sector too) to avoid an NHS view of the world.
- The NHS needs to avoid creating another layer of management. Flatter structures with good open governance will be needed.
- These sort of envisaged changes need good sustainable local leadership. In particular investing time and effort in relationship building, trust and overcoming some current cultural behaviours. Leadership development needs to be inclusive of potential leaders from all sectors including general practice and wider primary care.
- We need to create the time and funded backing for clinicians to be at the centre of building all these arrangements. This will not be an easy challenge given the increasing gaps in our experienced clinical workforce. There are no easy 'quick fixes' for this. We do need high calibre GPs to get involved in this agenda. This may be our biggest challenge.
- It will be important to demonstrate to system regulators real improvements in health and social care. That will need clear, agreed, achievable outcomes and timescales. Funding and service change will need to underpin these priorities which will then hopefully drive local integration programmes.
- We will need to align financial and non- financial incentives and funding to support emerging new models of care. This might also avoid large Acute sector organisations dominating the future landscape.
- If PCNs are to do anything in all this they will need a lot of support to make change happen – staff – the resource to engage - permissions to change pathways- risk/benefit arrangements- less performance management – help to have a more focused view on outcomes .

- ICPs will need to engage with a wide range of stakeholders, patients and the 'well' population in the plans and work underway. They also need to listen to concerns about the new contracts i.e. MCP.

Finally we need a clear view of the likely end point of current developments to provide the greatest clarity of the direction of travel for all local leaders (not just NHS or Local Authority although these are core to the changes).

## What Next for the LMC?

In 2018 the Cheshire LMC decided to look in some detail at how it would develop and address its role as a voice for all GPs in Cheshire irrespective of their contract status. We initiated a Fit for the Future Programme which has already guided several changes to our structure, engagement and member services.

We need to ensure Primary Care Networks are supported and appropriately (including leadership development). This in itself is an issue for general practice given the workforce recruitment issues nationally and locally. PCNs were set up to support the workload in general practice but it is clear other views will impact on GP time if they are to have an effective role in many of the above challenges. We also need to build on the relationships some of our GP Federations have invested in.

We also need to carve out the member time - possibly via our LMC 'Executive Team' structure to support the organisational relationship developments. We are actively engaged with NHSE, the new CCG and emerging ICPs. Community and Local Authority structures may be the areas for renewed action early in 2020.

There is also a need to continue our current engagement with organisations such as the NW Leadership Academy, Deanery and the GP Enhanced Training Hubs.

This paper aims to set the wider scene as we revisit our efforts to work with leaders in the emerging local system organisations, which forms part of our Annual Work Programme currently being finalised for 2020/21.

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