Humberside Primary Care Collaborative

Primary Care Leadership and Representation in HCV ICS

1. Context

Humber Coast and Vale ICS will bring NHS providers, Clinical Commissioning Group (CCGs), local authorities and voluntary sector partners together to collaboratively plan and organise how health and care services are delivered in their area. There are currently 42 ICSs across England and each covers a population size of between one and three million. The goal is that ICSs will remove barriers between organisations to deliver better, more joined up care for local communities. While they are currently informal partnerships, the government's white paper Integration and innovation (February 2021), states that the forthcoming NHS Bill will make ICSs legal bodies, and give them responsibility for funding, performance and population health. The ICS will be directly accountable to Parliament for NHS spend and performance within its system.

Currently CCGs have delegated responsibility for the commissioning of general practice. Community pharmacy, dental and optometry services are directly commissioned by NHS England and Improvement. The current CCG governing body and GP membership model will be replaced by a board consisting of representatives from the system partners. As a minimum it would include representatives of NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer. The ICS body should be able to appoint such other members as it deems appropriate allowing for maximum flexibility for systems to shape their membership to suit the needs of their populations. The power of individual organisational veto should be removed. The ICS Chief Executive would be a full-time Accounting Officer role, which would help strengthen lines of accountability and be a key leadership role in ensuring the system delivers.

The government wants to make ICSs legal entities in the Health and Care Bill, which is expected to be implemented in April 2022 although there has been recent discussion about extending this time frame. The ICS will not require a PCCC however ICS governance will have to be in place to make decisions akin to national contract regulations.

The ICS structure will have two parts.

- The first part will be an **ICS NHS Body** with a unitary board that will oversee the day-to-day running of the NHS locally. The ICS NHS Body will manage a single pot of NHS funding, and develop a plan to meet the health needs of the population within the ICS. The ICS NHS Body will take on the commissioning functions currently held by CCGs, but will take a more strategic approach to planning and monitoring services. The board will be comprised of an ICS lead, ICS chair and representation from **general practice,** trusts and local authorities. However, it is unlikely that all provider organisations will be directly represented on the board of the ICS NHS Body, as the board will need to avoid becoming too large and unwieldy.

- The second part of the statutory ICS will be the **ICS Health and Care Partnership**. With a wider membership than the ICS NHS Body, the Partnership will bring together health, social care, public health and wider partners to develop a broader strategic health, public health and social care plan for the ICS. General practice will be represented on the Partnership. The ICS

NHS Body will need to take this plan into account when making decisions about health care provision.

If the new integrated care proposals draw PCNs from communities towards the wider health and care system, and away from their core focus of developing and extending local primary care, there is a risk that primary care teams may come to feel that their PCN is no longer theirs, but is more directed from the centre. This risk will be magnified if the need to straddle both neighbourhood and place results in PCNs merging to become larger primary care provider organisations. PCNs will need to work together to identify the needs of primary care within integrated care systems and how they vary depending on local context. System-wide priorities must be balanced with the need to support locally-led changes by PCNs and their partners.

The abolition of CCGs will drive a requirement for a new model of primary care representation that embodies the principles of integration and innovation with other health sectors and across general practice, dental, pharmacy and optometry. All of these are at their heart, neighbourhood health care services. This local subsidiarity and control is key to unlocking the potential for collaboration as a primary care body to face the challenges collectively.

2. System Levels

The ICS structure will follow a similar architecture and whilst local design will be reflected in the functions at each level, a common understanding from NHS publication Designing integrated care systems (ICSs) in England (June 2019) of each level is:

Level	Functions
Neighbourhood (30k to 50K+ population)	• Integrated multi-disciplinary teams • Services (e.g. social prescribing) drawing on resource across community, voluntary and independent sector, as well as other public services (e.g. housing teams). • Proactive role in population heath and prevention • Strengthened primary care through primary care networks – working across practices and health and social care
Place (0.25 – 0.5 million population)	• Typically council/borough level • Integration of hospital, council and primary care teams / services • Develop new provider models for 'anticipatory' care • Models for out-of-hospital care around specialties and for hospital discharge and admission avoidance
System (1 – 3 million population)	• System strategy and planning • Develop governance and accountability arrangements across system • Implement strategic change • Manage performance and collective financial resources • Identify and share best practice across the system, to reduce unwarranted variation in care and outcomes
NHSEI Regional	• Agree system objectives • Hold systems to account • Support system development • Improvement and, where required, intervention
NHSEI National	• Continue to provide policy position and national strategy • Develop and deliver practical support to systems, through regional teams • Continue to drive national programmes e.g. Getting It Right First Time (GIRFT) • Provide support to regions as they develop system transformation teams

3. Primary Care Leadership and Representation

The NHS publication Legislating for Integrated Care Systems: five recommendations to Government and Parliament February 2021 sets out legislative recommendations which help understand the structures and opportunities for primary care representation and leadership in the ICS.

The legislation requires maximum local flexibility as to how an **ICS health and care partnership** is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where these work well. The composition of the board of the NHS ICS body:

- must be sufficiently streamlined to support effective decision-making
- must be able to take account of local circumstances as well as statutory national guidance
- the members of the NHS ICS Board must include a chair and CEO and as a minimum also representation from NHS trusts and Foundation Trusts, **general practice**, and local authorities.

As with CCGs now, NHSEI should approve all ICS constitutions in line with national statutory guidance.

In the January 2021 NHS publication Integrating care Next steps to building strong and effective integrated care systems across England consideration is given to how ICSs could be embedded in legislation or guidance and sets out options for the structure of ICSs. Each system should define:

- **Place leadership** arrangements. These should consistently involve:
    - every locally determined 'place' in the system operating a partnership with joined-up decision-making arrangements for defined functions
    - the partnership involving, at a minimum, **primary care provider leadership**, local authorities, including Director of Public Health and providers of community and mental health services and Healthwatch
    - agreed joint decision-making arrangements with local government
    - representation on the ICS board

    They may flexibly define:

    - the configuration, size and boundaries of places which should reflect meaningful communities and scale for the responsibilities of the place partnership
    - additional membership of each place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and other partners
    - the precise governance and decision-making arrangements that exist within each place
    - their voting arrangements on the ICS board

- **Provider collaborative leadership** arrangements for providers of more specialist services in acute and mental health care. These should consistently involve:
    - every such provider in a system operating as part of one or more agreed provider collaboratives with joined up decision making arrangements for defined functions
    - provider collaboratives represented on the appropriate ICS board(s)

- At Humber Coast and Vale ICS our size and complexity the ICS determines that we will be represented through multiple geographic operating arms. Representation on the ICS can be achieved through one or more operating arms rather than the whole. The emerging Humber and Place arrangements will help to demonstrate this.

4. Clinical Leadership

Clinical and other frontline staff will need to be supported to continue to play a significant leadership role through systems. ICSs should embed system-wide clinical and professional leadership through their partnership board and other governance arrangements, including primary care network representation. Primary care clinical leadership takes place through critical leadership roles including:

- Clinical directors, general practitioners and other clinicians and professionals in primary care networks (PCNs), who build partnerships in neighbourhoods spanning general practice, community and mental health care, social care, pharmacy, dentistry, optometry and the voluntary sector
- Clinical leaders representing primary care in place-based partnerships that bring together the primary care provider leadership role in federations and group models
- Dental, pharmacy, optom leadership
- A primary care perspective at system level

System-wide clinical leadership at an HCV ICS and provider collaborative footprint through clinical networks should:

- be able to carry out clinical service strategy reviews on behalf of the ICS
- develop proposals and recommendations that can be discussed and agreed at wider decision-making forums
- include colleagues from different professional backgrounds and from different settings across primary care, acute, community and mental health care
- have the requisite skills, experience, expertise and credibility to influence and drive the primary care agenda
- embrace the shift in roles of GPs as clinical commissioners to agents of population health management – linked to neighbourhood leadership role.

5. Financial framework

It is likely that finances will be organised at ICS level and put allocative decisions in the hands of local leaders. There will be a single pot which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held transformation funding that is allocated to systems. ICS leaders, working with provider collaboratives will have a duty to distribute those resources in line with national rules such as the mental health, and the primary and community services investment guarantees and locally-agreed strategies for health and care. HCV will have a Humber allocation and a NYY allocation.

ICS leaders will also have a duty to ensure that they deploy the resources available to them in order to protect the future sustainability of local services, and to ensure that their health and care system consumes their fair share of resources allocated to it. As part of this, ICS leaders will be expected to use new freedoms to delegate significant budgets to 'place' level, which might include resources for general practice, other primary care, community services, and continuing healthcare.

Decisions about the use of all of these budgets will usually be made at the lowest possible level, closest to those communities they serve and in partnership with their local authority.

6. Proposals for Primary Care leadership and representation

The structure of Humber Coast and Vale ICS is being developed to allow shadow form functionality 1st October – 31 March 2022.

A series of primary care leadership and representation options are proposed based on an assumption of the ICS structures. For some of the ICS component levels it will be necessary to develop a role description essential skill set for primary care representatives. These proposals are for the purposes of discussion and development of an agreed model.

ICS component	Menu of suggested options which can be selected for each ICS component		
a) ICS NHS Executive Body* (The primary care transitional executive group exists currently with LMC representation)	*1 GP/ CD from each Place – 6 in total* *2 LMC secretariat representatives*	*1 GP/CD North and North East Lincs, 1 GP/CD Hull and East Riding and* *1 GP/CD Vale of York, Scarborough and Rydale* *2 LMC secretariat representatives*	*1 GP to represent all 6 Places* *2 LMC secretariat representatives*
b) ICS Health and Care Partnership*	*2 Primary Care reps* *1 rep from LMC*	*1 rep from general practice* *1 rep from Primary care* *1 rep from LMC*	*6 reps from general practice* *1 rep from Optoms* *1 rep from Pharmacy* *1 Rep from Dental* *2 reps from LMC*
c) Place Partnership	*28 CDs are represented across their geographical Place areas*		
d) Other Provider Collaboratives	*1 GP/CD to represent Humber and N Yorks on each collaborative*	*1 GP/CD to represent Humber and* *1 GP/CD to represent N Yorks on each collaborative*	*2 LMC secretariat representatives on each collaborative*
e) Humber Partnership There are bi monthly Exec and quarterly development sessions, and a 2 weekly clinical board.	*1 GP/ CD from each Place – 4 in total* *1 rep from Optoms* *1 rep from Pharmacy* *1 Rep from Dental* *1 LMC secretariat representative*		
f) Neighbourhood	*Primary Care Network Clinical Directors represent their Neighbourhood*		
g) Other design and integration groups	*GP representation by specialism to each group supported by funding and infrastructure*		

**Outside remit of Humber Primary Care Collaborative*