Consultation response
January 2021

NHS CONFEDERATION
PCN Network

Integrating care: Next steps to building strong and effective integrated care systems across England

Key points

- To produce this response, the PCN Network has engaged with PCNs across the country through a series of virtual roundtable events. These roundtables provided a platform for those working within PCNs, including clinical directors and network managers, to discuss the NHS England and NHS Improvement (NHSEI) proposals and offer their views and concerns.

- Overall, there is cautious optimism among PCNs about the direction of travel set out in NHSEI's paper. It is broadly felt that formalising system working and embedding collaboration at place will be beneficial for population health in the long term.

- The reason for caution is that while there is support for many of the basic premises set out in the paper, there is concern about what the detail will look like in certain areas. Notably, these include:
    - the division of responsibilities between system and place
    - governance and PCN representation within systems
    - the financial risk to primary care budgets.

  More comprehensive concerns on these issues and others are provided in answer to the four questions posed by NHSEI.

- Without knowing such details, it is difficult for PCNs to visualise how systems will operate in future and what the PCN role will be within them. Our response can therefore be summarised with a quote from one clinical director who said: "the devil is in the detail and the detail doesn't exist".

Question 1: Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

- **Broadly, yes**. There is a sense across the PCNs we have engaged with that to provide certainty on issues relating to finance and accountability, it is right that ICSs are given statutory footing.

- On timescales, however, there is concern among some PCNs that the proposed timeline of ICS statutory footing by 2022 will feel rushed. PCNs nationwide are at different stages of development. Ensuring that their network is operating effectively, managing vaccinations and recruiting staff through the Additional Roles Reimbursement Scheme (ARRS) are the key priorities. Many believe that PCNs are not yet mature enough to provide a 'single PCN voice' within a system. The lack of established mechanisms to ensure that PCNs across an ICS have a voice at system level has led to a sense that PCNs are 'being done to' rather than leading.

- Part of this concern relates to leadership and development. Looking outside one's PCN and to the bigger aims of the system will require a different kind of leadership from clinical directors (and non-clinical leaders), as well as the ability to think outside general practice and primary care. We must invest in leaders across primary care to adapt to these new demands. It will also require resourcing – clinical directors do not carry out their roles full time and if they are to effectively contribute to system-level working then this time commitment and additional workload needs to be recognised.

- There is some confusion and concern as to why integrated care partnerships (ICPs) at place level and PCNs at neighbourhood level will not also be given statutory footing. There is reference in the paper to decision-making powers and responsibilities being devolved down from system to place where possible, yet how will this happen without place-level structures being made statutory is unclear. This has led some to question how the principle of subsidiarity will be realised in practice.

- Crucially, the knowledge, skills and supporting function of commissioners in CCGs must not be lost in the move to ICSs. For many PCNs, a named person in their CCG is important in providing support. Clinical directors have said they will miss this and we must ensure this supportive kind of relationship is not lost in the transition, with many PCNs still developing.

Question 2: Do you agree that option two offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to parliament and most importantly, to patients?

- **Yes**. Option 2 is clearer in terms of accountability and will give the autonomy to local leaders that will be needed to improve population health at system level.

- There is an expectation that systems will enable better collaboration across providers. This has, to date, been patchy and the experience during COVID-19 has seen some powerful examples and some less effective. If primary care is to become an equal partner within the system, then the system needs to facilitate this.

- There is a lack of clarity so far on what the role of residents, patients and communities will be at neighbourhood, place and system levels. Perhaps this is to be left to individual systems to clarify but there is a sense that there needs to be more consistent reference to how future reforms will affect them, given that they are supposed to be the beneficiaries.

- To address the above, NHSEI and/or the government should set minimum standards around lay involvement and robust public accountability mechanisms. It is welcome that there is a role for health and wellbeing boards (HWBs) within place, but it is not clear how public scrutiny will work at system level.

Question 3: Do you agree that, other than mandatory participation of NHS bodies and local authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

- PCNs believe that governance arrangements in systems should be subject to clear minimum requirements and that systems are at risk of becoming too distant from primary care. The current requirement for PCN 'representation' at system level is vague and currently suggests a small number of PCNs in a system have influence and voice. NHSEI and the government must avoid systems being left to shape their own governance arrangements, and this being to the detriment of PCN input and involvement. The PCN Network will lead a piece of work in early 2021 to develop set of minimum standards for PCN engagement at system and place level.

- As outlined in question 1, there is a concern over resourcing, and we are clear that additional resources, such as administrative and managerial support, must be made available to help PCNs carry out their duties in contributing to their system in addition to their existing work.

- Finally, while PCNs are clear that they would like opportunities to contribute to system planning and strategy, they are concerned about having to consistently 'manage upwards' – needing to seek permission to make decisions for the local populations. Many PCNs have operated efficiently because they have not had an unwieldly framework to slow down decision-making. Systems need to have a process to understand and reflect the needs of PCNs as much as PCNs need to understand the workings of the system in which they operate.

Question 4: Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

- **Partly**, however this will depend on the services in question. There is concern about the future of primary care funding falling within the remit of individual systems (and primary care competing against others for a share of a 'single pot' of funding). The contracts that primary care hold with NHSEI represent a guaranteed 'baseline' of funding and this must not be lost. As such, PCNs want to see a commitment to primary care budget protection.

- With regards to specialised commissioning, some services lend themselves well to devolution to system level or clusters of systems regionally (such as kidney dialysis). Devolving such services makes sense if it allows systems to plan around the entire continuum of care (improved preventative care can lead to less need for high end/cost interventions further down the line).

- However, there is good reason for certain aspects of specialised commissioning being held at national level, not least to ensure national consistency in service quality for the most difficult and most expensive conditions to treat. Some services are so specific and high cost that they would be better retained at national level. Such services include those relating to rare diseases.