**Primary Care Provider Collaboratives (PCPCs) – Guidance for LMCs**

This document provides guidance for Local Medical Committees (LMCs) and general practices wishing to develop Provider Collaboratives in their areas. It should be read alongside the following resources produced by GPC:

[*ICB Draft Blueprint Guidance GPC*](https://cdn.intelligencebank.com/eu/share/qMbw14/NZMLN/jgWvv/original/BMA%2BGPC%2BEngland-%2BNavigating%2Bthe%2BRisks%2Bfor%2BGeneral%2BPractice%2B%E2%80%93%2BA%2BResponse%2Bto%2Bthe%2BICB%2BDraft%2BBlueprint%2BNEW%2BTEXT%2B24.06%2BFINAL)

*[Focus on Ethics pdf](https://i.emlfiles4.com/cmpdoc/2/5/8/0/5/3/files/12475_focus-on-ethics.pdf)*

*[Focus on Neighbourhood pdf](https://i.emlfiles4.com/cmpdoc/2/5/8/0/5/3/files/12473_focus-neighbourhood.pdf)*

The Department of Health and Social Care (DHSC) and NHS England (NHSE) have invited Integrated Care Boards (ICBs) and Local Authorities to join the first wave of the *National Neighbourhood Health Implementation Programme (NNHIP)*. GP practices, federations and PCNs should consider how they will operate in these systems by developing collaborative models based on transparent and ethical principles that protect both member practices and patient care.

Without strong, aligned voices from general practice, LMCs, PCNs, and federations, system redesign risks being imposed externally, potentially misaligned with the realities of general practice and wider primary care and resulting in poorer outcomes for patients. In the absence of effective provider collaboration, key commissioning powers may be transferred to Trusts or underdeveloped neighbourhood collaboratives, bypassing general practice entirely.

LMCs across England have shared examples of Terms of Reference (TORs) for existing collaborative models, ranging from GP Provider Boards (practices, PCNs and federations) to wider PCPCs (including general practice, pharmacy, dentistry, and optometry). These models are at varying stages of maturity.

**Definitions:**

* *Primary Care* – The first point of contact for healthcare, including general practice, community pharmacy, dentistry, and optometry.
* *General Practice* – A subset of primary care, providing comprehensive medical care led by GPs and their teams, characterised by continuity of care, patient advocacy, and coordination of long-term condition management and prevention.

This guidance draws on discussions with multiple LMCs and may be used to support the development of local collaborative structures. The sections below can be incorporated into associated TORs. LMCs, with their unique expertise and understanding of local provider structures, are well-placed to help design effective collaborative structures that amplify patient outcomes and ensure primary care is supported within the wider system. General practice, with its patient advocacy role, deep understanding of patient need in the local context, and extensive experience in coordinating care, is particularly well positioned to lead this transformation for wider primary care and should be firmly embedded in any emerging new structures.

**1. Key Principles**

**i) Subsidiarity**

* Support delivery at the scale that best achieves the overall strategy of improving outcomes and reducing inequalities (e.g. Practice, Pharmacy, PCN, Place, System).
* Deliver services at the smallest effective scale where possible.
* Use larger-scale delivery only when required (e.g. due to resources).
* Document and communicate all decisions about scale of delivery.

**ii) Sustainability**

* Activities must not undermine sustainability at the smallest delivery unit (e.g. individual practices).
* Applies regardless of scale of delivery or decision-making.

**iii) Openness, Transparency, and Accountability**

* All actions and recommendations must adhere to these principles.

**2. Purpose**

* Improve patient care and outcomes.
* Strengthen and represent general practice and primary care’s role within health and social care systems.
* Focus on supporting the development of suitable pathways for primary care to manage patients within the Integrated Care System.
* Ensure general practice perspectives are represented at system and place discussions, with no major decisions taken without PCPC involvement.
* Provide infrastructure for service delivery, quality improvement, and collaboration.
* Secure parity of influence with other sectors (e.g. mental health, community, acute care).
* Identify opportunities to expand the range of services deliverable within primary care.
* Support primary care in fulfilling contractual obligations, with LMC support where appropriate.

**3. Authority and Status**

* PCPC is a non-statutory collaborative of NHS-funded primary care providers.
* Provides a governance framework for collaborative working between providers, aligned with PCPC principles.
* Not a legal entity; member organisations remain sovereign.
* Cannot take decisions separately from the member practices or bind any of them.
* The Board’s authority is limited to PCPC activities.
* The PCPC Board operates as a forum for discussion and consensus-building.

**4. Responsibilities of the Board**

* Provide strategic leadership for collaboration.
* Promote equity for primary care in system wide planning.
* Enable two-way communication with system partners.
* Use robust communication methods to ensure the full engagement of primary care.
* Support transformation and improvement (e.g. working with federations and others to deliver at scale where appropriate).
* Ensure alignment with system strategic priorities.
* Provide a unified voice for primary care.
* Act as ambassadors for primary care in system-wide discussions.
* Continuously develop, agree and update PCPC purpose and principles.
* Remain responsive to national policy and regulatory changes.
* Manage conflicts of interest in accordance with member organisation’s conflict of interest policies and statutory duties.
* Maintain confidentiality of privileged or sensitive information.

**5. Accountability**

* Members remain accountable to their places, PCNs, practices, and local GP systems in line with the principle that the PCPC Board is not a separate legal entity, but a forum for discussion of issues with the aim of reaching consensus between members.
* Regulatory accountability remains within each sovereign organisation.

**6. Structure and Membership**

**Suggested Board Composition**

* GP (PCN Clinical Director), pharmacy, optometry, and dentistry leads for each place.
* LMC leads (and potentially LDC, LOC, LPCs). LMCs may best act as non-voting members to influence and advise whilst ensuring that practices have a voice.
* Practice manager leads for each place.
* Independent Chair and Deputy (two-year term).
* Non-voting administrator.
* Invitees by invitation as needed (e.g. ICB staff, project leads).
* Outline the “Place” level infrastructure, roles and responsibilities dependant on the geographical area your PCPC needs to cover.

**7. Meetings – Quoracy and Decision-Making**

* Monthly or fortnightly meetings, with informal dialogue in between as required.
* Held virtually or in person.
* Agenda set by Board and Chair, circulated at least 5 days in advance.
* Quorum: minimum of 4 members in attendance, including Chair/Deputy.
* Decisions made by consensus where possible.

**8. Delegation**

Activities may be delegated to:

* LMCs
* Practice Manager Associations
* GP Federations
* Community Pharmacy, Optometry, Dentistry
* Delegation must uphold subsidiarity and sustainability.
* The PCPC will retain an assurance function in these activities.

**9. Administration**

* Secretariat to prepare agendas, minutes, and action logs.
* Monitor progress against actions.
* Maintain a register of interests of members.
* Maintain communication and document management.
* Communicate key priorities and rationale for decision making via newsletters, forums, LMC meetings, WhatsApp, PCN meetings, etc.

**10. Review and Evaluation**

* Obtain regular feedback on communication methods.
* Annual TOR review.
* Changes require Board approval.

**Further Considerations for LMCs**

**1. Sustainable Pace**

* Avoid rushing through structural changes without necessary governance or sufficient support from the profession.
* Be proactive rather than reactive.

**2. Funding**

* Currently no dedicated funding for PCPCs.
* Explore ICB funding opportunities for meeting attendance. Use existing examples of delegated ‘place’ budgets and QI capability to evidence a demonstration of commitment to developing neighbourhood health.
* LMCs may choose to fund their attendance via the levy to retain independence.
* Optimise resources (e.g. seconded administrative support from federations). Make use of existing funded clinical and management time where possible (such as for Clinical Director roles).

**3. Communication and Relationships**

* Successful collaboration relies upon effective communication, trust, and relationship-building to bring about a symbiotic relationship which amplifies outcomes and impact.
* Engage practices and wider system provider organisations early on.
* Map risks and opportunities collaboratively.
* Align with neighbouring LMCs where footprints are not coterminous.
* Support staff with training and morale.
* Regularly review progress, adapt strategies, and remain responsive to feedback.
* Identify general practice allies.

**4. Governance and Ways of Working**

* Establish clear governance and joint working principles both within general practice structures and at the interface with other organisations (for example with secondary care and community services). When clearly articulated and recorded, this will act as a road map and rule book for all providers in a shifting landscape.
* Ensure LMC alignment across ICB footprints.
* Consider Memoranda of Understanding (MOUs):
	+ *With practices* – to secure mandate if transitioning to a decision-making body (ensure LMC involvement at all stages).
	+ *With provider organisations* – to confirm joint working principles, communication, and data-sharing protocols.
	+ *With the ICS* – to define governance, outline infrastructure, monitoring and reporting requirements, roles and responsibilities (e.g. any system support for the Board), financial agreements, and engagement at system meetings.

**5. Values**

* Define co-created, shared values and agree a code of conduct.

**6. Keeping General Practice Central**

* GPs should maintain a central, coordinating role much like the ‘conductor of an orchestra’.
* Weight GP and LMC membership accordingly.

**7. Ringfencing Surplus for Purpose**

* Financial surpluses (e.g. from reduced hospital activity, innovation, contractual delivery or delegated commissioning) should be reinvested into member practices’ services and staff generating even more gains by improving preventative and continuity of care.
* Reinvestment should reward collaboration, quality and outcomes—not activity alone. This will support practices to work together for population benefit, not individual gain.

**8. Organisational Models**
As outlined in GPC’s *Focus on Ethics* document, possible organisational models to implement collaborative working include:

* Mutuals/Cooperatives
* Community Interest Companies (CICs)
* Limited Companies with Shareholder Agreements.