Hewitt Review

January 2023

The Royal College of General Practitioners (RCGP) welcomes the opportunity to respond to the Hewitt Review into how the oversight and governance of Integrated Care Systems (ICSs) can best enable them to succeed.

The RCGP is the largest membership organisation in the UK solely for GPs, with over 54,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. The RCGP is an independent professional body with expertise in patient-centred generalist clinical care.

Overview

We have previously called for the balance between high-level oversight and planning and local flexibility for ICSs to be driven by what will most benefit patient care.

ICSs have been designed to improve outcomes in population health through supporting integrated care and enabling better patient pathways through the system. In theory they could provide a stronger population health focus than CCGs, but their ability to deliver on this will rely on their ability to maintain this focus in the face of many other competing pressures from politicians and the public, as well as the outcome measures that are used.

Integration of care is about placing patients at the centre of the design and delivery of care. It leads to better outcomes for patients, safer services and improved patient experience, and can also act as an enabler of more cost-effective care. As such, it is an urgent priority for the NHS, particularly at a time when the number of patients with long term and complex conditions is rising, and when services are under growing financial strain.

Empowering local leaders

1. **Please share examples from the health and care system, where local leaders and organisations have created transformational change to improve people's lives. (250 word limit). This can include the way services have been provided or how organisations work with residents and can be from a neighbourhood, place or system level.**

The vaccination scheme rolled out during the COVID-19 pandemic demonstrated the remarkable work that can be done when local systems are fully enabled to develop solutions that meet the needs of their populations. GP practices, clusters, and PCNs worked rapidly to develop entirely new service delivery models for the COVID-19 vaccination scheme that have, to date, provided 151,248,000 vaccinations across the UK.

This example shows the benefits of a high-trust, low bureaucracy model for resource allocation, and that aligning funding with meeting certain criteria or 'tick-boxes' does not promote best practice in patient care. It also shows the benefits that can be achieved when patients are reached in the ways that suit them best, through systems designed to meet their needs. Examples of general practice activity to vaccinate hard to reach populations can be found on our website here.

At a neighbourhood level, the Bromley-by-Bow Centre in London serves as an example of transformational integrated care. The Centre is a community charity offering over 40 services to the community, including primary care services, employment support, adult social care, activities and social groups, and skill courses. Clinicians work across this integrated system of services to provide holistic treatment that is reflective of patient need and circumstance, including a focus on social prescribing, working with extended teams to address these while maintaining GP continuity.

2. **Do you have examples where policy frameworks, policies and support mechanisms have enabled local leaders and, in particular, ICSs to achieve their goals? (250 word limit) This can include local, regional or national examples.**

The RCGP would like to see the Quality Outcomes Framework (QOF) extensively reduced with a move instead towards schemes that incentivise quality care, enable GPs to focus on the needs of patients in their local areas, and limit unnecessary bureaucracy.

The Somerset Practice Quality Scheme (SPQS) was trialed as a local alternative to QOF in 2014. The trial removed the link between QOF indicators and practice funding, instead incentivising practices to work collaboratively with their CCG. Most practices found the associated time savings led to increases in person-centred coordinated care and strengthened system networks. Similarly, the General Practice Alert State trial currently being run by Devon LMC was designed

for QOF to be paused, among other measures, when practices in the region report a high alert state. These examples of local systems being able to tailor the delivery of services to clinician and patient need offer positive alternatives to the current trajectory of GP burnout, resignation, and falling patient care.

Cheshire and Merseyside Integrated Care System recently developed a set of principles for the development of patient pathways between primary and secondary care. These principles provide a set of guidelines by which service providers can recognise the impact of their actions on other areas of the system and enable them to work more collaboratively with other providers. The principles have been successful in enabling positive working relationships across the system and ensuring patient-centred processes are prioritised.

3. **Do you have examples where policy frameworks, policies, and support mechanisms that made it difficult for local leaders and, in particular, ICSs to achieve their goals? (250 word limit). This can include local, regional or national examples.**

A limited voice for general practice

Empowering local leaders to deliver truly integrated care requires that those leaders' voices are adequately represented at higher levels in the system. At present, Integrated Care Boards (ICBs) are only required to have one primary care representative on the board, and a medical director at board level. There is no guarantee of further primary care representation on ICBs, or that the primary care representative will be based within general practice. The lack of a strong primary care, and especially general practice, voice within ICSs will hinder the ability of systems to improve outcomes in population health and develop cost-effective services.

Lack of workforce planning and retention schemes

ICSs cannot deliver the care patients need without the workforce to deliver it. Regional ICS planning is ineffective without broader, national planning to ensure the NHS has the workforce it needs to function.

It is significantly more cost-effective to retain existing staff than to train and develop new staff. It is currently unclear how many ICSs have local retention schemes in place, for example building on the local GP retention pilots and GP fellowships for early career GPs. While there is some funding available nationally for developing local schemes, this is limited and feedback from our members suggests that local retention schemes are often difficult to find or to establish. We understand that NHS England is currently undertaking a review of all retention and recruitment schemes; this will be important for identifying and understanding the current challenges.

4. **What do you think would be needed for ICSs and the organisations and partnerships within them to increase innovation and go further and faster in pursuing their goals? (250 word limit)**

Time: While it is crucial that systems are held to account for their progress in improving outcomes, ICSs and PCNs are still in an early stage of development. They must be given the time to develop the relationships and pathways across the system that will be required to deliver integrated care.

GP voice: Innovation grows from the ground up. Entrenching space for local leaders in ICS decision-making will build innovation and feasibility into the types of interventions that are designed, and shape the direction of resource allocation towards preventative care.

Resource: Many ICSs are carrying historic deficits and operating in financially constrained environments, yet being asked to develop significant new ways of working. This approach is unlikely to be successful, and additional resource is needed for them to establish properly.

Support: No other sector would expect to achieve the degree of change required of the health and care sector without investment in change management support. The lack of a systematic and planned transition towards new ways of working is likely to amplify costs and productivity inefficiencies. PCNs, in particular, need sufficient investment in leadership and management capacity to deliver the changes in service delivery that are expected of them.

Trust: A high-trust environment, in which systems are allowed to fail, is required to encourage innovation in delivery of services. For ICSs and service providers to be able to deliver care differently, different priorities in standard-setting and accountability are required.

5. **What policy frameworks, regulations or support mechanisms do you think could best support the active involvement of partners in integrated care systems? (250 word limit). Examples of partners include adult social care providers, children's social care services and voluntary, community and social enterprise (VCSE) organisations. This can include local, regional or national suggestions.**

The development of effective partnerships requires a positive culture of inclusion and collaboration to achieve shared population health outcomes. The establishment of Integrated Care Partnerships (ICPs) will go some way to ensuring VCSE partners are adequately involved and represented in the functioning of ICSs. However, the size and diversity of the VCSE sector can create challenges for engagement; it will be important for ICPs to support and enable the structures and relationships that are already forming. Adequate funding and protected time will be required for VCSEs to fully participate in these systems.

National targets and accountability

6. **What recommendations would you give national bodies setting national targets or priorities in identifying which issues to include and which to leave to local or system level decision-making? (250 word limit)**

The healthcare system is already subject to a vast number of targets, driven primarily by political and managerial agendas rather than the benefits to patient care. Each additional target diverts time, focus, and resources from core goals and increases bureaucracy for the NHS.

Change management principles recognise that change works best when driven from the bottom up, and we believe schemes designed by and for local populations have the best success. The design of services should sit as close as possible to the entity delivering them to ensure they are relevant to the target population and achievable for the service provider.

Central performance targets should be avoided where possible. Where they are set, bodies should ensure they are evidence and outcomes-based and recognise improvements to services rather than achieving strict criteria. Targets related to population health, service access, clinical outcomes, and interactions between primary and secondary care in particular should be closely evaluated to ensure they are relevant to local systems, which are being encouraged to address these issues differently. Any targets should not exacerbate health inequalities and should be support patient autonomy and shared and evidence-based decision making.

7. **What mechanisms outside of national targets could be used to support performance improvement? (250 word limit) Examples could include peer support, peer review, shared learning and the publication of data at a local level. Please provide any examples of existing successful or unsuccessful mechanisms.**

The NHS is in crisis. Performance improvement cannot be achieved without addressing the fundamental issues of unmanageable workload, falling workforce numbers, and increasing clinician stress. Mechanisms such as those suggested will simply not be enough to mitigate the falling quality of patient care driven by these current pressures.

In general practice, increasing numbers of patient contacts and increasing levels of bureaucracy are hindering clinicians' ability to undertake broader work around quality improvement. Incorporating protected time for clinicians into the GP contract, as has recently been done in Scotland, would provide some additional headroom for GPs to consider how they deliver their services and what additional improvements could be undertaken.

Sharing QI tools and examples of good practice could support practices to adopt systems that would increase productivity and clinician and patient experience. Encouragement by systems of QI-based approaches to patient management at the local level can enable innovation and improvements to patient outcomes, such as interventions organised between PCNs like this example from Tower Hamlets.

Finally, there is substantial evidence of the effectiveness of continuity of care, in delivering improved patient experience, better health outcomes, reduced mortality, improved clinician satisfaction, and improved cost-effectiveness for the NHS. Mechanisms that seek to encourage the principles of continuity of care would support performance improvement across a range of metrics.

Data and transparency

8. **Do you have any examples, at a neighbourhood, place or system level, of innovative uses of data or digital services? (250 word limit) Please refer to examples that improve outcomes for populations and the quality, safety, transparency or experience of services for people; or that increase the productivity and efficiency of services.**

The Fuller Stocktake shared a case study from Brent, in London, where 20 practices created a centralised 'eHub' for online consultation management. The eHub combined individual practice eConsult systems into a centralised hub, allowing clinicians to work cross-practice to deliver care. Available GPs can undertake consultations with patients who have requested support via the hub regardless of their 'home' practice, including offering telephone and face-to-face consultations. The eHub closes around 90% of online consultations, reducing the pressure on home practices and reducing waiting times for services, increasing time for practices to focus on patients with more complex needs.

9. **How could the collection of data from ICSs, including ICBs and partner organisations, such as trusts, be streamlined and what collections and standards should be set nationally? (250 word limit)**

While it is important that appropriate data are available for healthcare planning and research, all efforts should be made to streamline collection to avoid unnecessary administrative burden. Principles of data minimisation should be applied with only the specific information required collected and consideration given to whether an appropriate data set is already available. Similarly, a clear use case should be in place for all data collected to avoid wasted effort.

For example, during the pandemic, a requirement was put in place for vaccinators to record patient ethnicity at the point of COVID-19 vaccination despite this information already being held for the majority of patients. Ultimately, the RCGP understands that the ethnicity data collected were not used but resulted in significant wasted time when extrapolated across millions of vaccination events.

Data security standards should also be set, ensuring that health data, sensitive by their nature, are held and accessed within trusted research environments/secure data

environments, as per the Ministerial commitments regarding the GP Data for Planning and Research Programme[1]. Clear data security standards, as well as clear reasons for data collection and minimising the data collected, will also help to promote public and healthcare professional trust.

The unintended consequences of data collection, and particularly publication, must also be carefully considered. For example, recent publication of practice-level GP waiting time data has led to negative press coverage at a time of enormous pressure on general practice, as well as risking disicentivising the appropriate offering of advance appointment booking[2].

10. What standards and support should be provided by national bodies to support effective data use and digital services? (250 word limit)

In our tracking survey of 1626 GPs carried out in Spring 2022, the following percentages reported that elements of their technology were not of an acceptable standard:

- WiFi quality or speed - 51% of GPs;
- Ability of their GP computer system to exchange information with those in hospitals -64% of GPs;
- PC/laptop software - 49% of GPs;
- Technology for online/video consultations in practice - 32% of GPs[3]

As we move towards a more joined-up approach to working across health and social care, ICSs should be developing plans to support primary and secondary care to develop digital solutions together to ensure interoperability is embedded by system developers. Central government must therefore provide adequate support and flexibility to support the ability of ICSs to lead this planning at the system level. To deliver integrated care, priority must be given to enabling different healthcare professionals to access the same patient records. Due to the nature of small individual practices, general practice often lacks the HR and IT support available in large hospital trusts, meaning particular resourcing and change management support will be needed in general practice.

In addition to a focus on interoperability, there must be a focus on addressing poor standards of existing digital infrastructure and software. This will require investment as well as national standards to ensure that systems are designed to meet the needs of patients, practices and the whole healthcare system, including via a focus on continuity of care, ease of use and data security.

System oversight

11. **What do think are the most important things for NHS England, the CQC and DHSC to monitor, to allow them to identify performance or capability issues and variation within an ICS that require support? (250 word limit)**

We recognise that a balance must be struck between regulation and flexibility to allow ICSs to deliver the goal of integrated care. However, increased top-down bureaucracy will only add more pressure to services at a time where workload is already unsustainable. Where regulation is proposed, it should be carefully examined to ensure it delivers positive outcomes for service providers and does not add another layer of bureaucracy.

The key potential for ICSs lies in the ability to look across the whole system to make decisions. Regulation of ICSs should focus on the delivery of outcomes that are in line with this higher-level strategic thinking and reflective of patient outcomes, and should not dip into clinical delivery areas that are more appropriate for PCNs and service providers who are actually delivering the work.

12. **What type of support, regulation and intervention do you think would be most appropriate for ICSs or other organisations that are experiencing performance or capability issues? (250 word limit)**

While independent support offers are being developed to support ICSs experiencing performance issues, centralised support should be provided by NHS England to ensure it is adequately resourced and accessible to all systems. Addressing capability issues must include the development of a national workforce plan and appropriate support for both local and national retention schemes.

Additional evidence

13. **Is there any additional evidence you would like the review to consider? (250 word limit) See the Hewitt review terms of reference as a guide to what additional evidence may be relevant.**

[1] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/general-practice-data-for-planning-and-research/about-the-gpdpr-programme

[2] https://www.rcgp.org.uk/News/Health-Secretary-Letter-Practice-Level-Data

[3] https://www.rcgp.org.uk/representing-you/future-of-general-practice