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8 January 2021

NHSE England and Improvement: Engagement on Integrating Care: Next steps to building strong and effective integrated care systems across England

Executive Summary

1. The Royal College of General Practitioners (RCGP) welcomes the opportunity to respond to the NHS England and Improvement (NHSE/I) engagement on integrating care and the recommendations for proposed changes to legislation.
2. The RCGP is the largest membership organisation in the UK solely for GPs. Founded in 1952, it has 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.
3. The RCGP is broadly supportive of the overall aims of the integrating care agenda outlined by NHSE/I. However, there are significant concerns from GPs that the proposals as they currently stand do not give adequate safeguards to ensure that the smaller providers in a system. These providers, including general practice, must be embedded at all levels of decision making and resource allocation and be enabled to shape strategy and transformation.

4. We would like to ensure that the implementation of any legislative changes incorporate a more realistic timeline to prevent an unnecessarily disruptive reorganisation of current system partners. The RCGP would be unable to support the recommendations as they stand, without the inclusion of proposals which address these important issues.

5. There appears to be clear agreement across the healthcare sector that a top-down restructure of organisations and accountabilities would be counterproductive. The proposals to put ICSs on a statutory footing, and for commissioning responsibilities to be absorbed into these organisations by 2022, is too short a timescale to necessary enable bottom-up, localised development. It would be preferable to wait a little longer and ensure all systems are in a better position to achieve meaningful change with all partners.

6. The success of Integrated Care Systems (ICSs) will not be on the basis of legislative change, but on the quality of relationships and engagement of the workforce delivering care for patients. The current proposals use Primary Care Networks (PCNs) as a favoured unit of primary care for engagement at the system level. Whilst we are very supportive of the development of PCNs and the potential role they could play in the integration agenda, these proposals seem to place unrealistic expectations on many PCNs over the next few years. It is widely recognised that PCNs are currently at widely varying stages of maturity, depending on a range of factors. Many networks need far more time and resource to develop in order to fulfil the system role envisioned for them. In the meantime, systems must develop specific plans to include existing general practice leadership with its wealth of experience in health management and commissioning to ensure strategies can take a holistic, system wide view of care.

7. While we agree that there should be legal provision for ICSs to become statutory bodies in the future, effective integration within the NHS would be much more likely if systems were given the space, time and resource to develop the necessary relationships and structures first. This could take several years and will require additional resource. This might mean using the first option set out in the proposals, of convening a system board, as a stepping-stone within legislation. This could then lead to a system absorbing Clinical Commissioning Group (CCG) responsibilities and structures when it is mature enough to do so.

8. A strong primary care system is a crucial element of effective healthcare systems. Primary care, and more specifically general practice, will need to be the foundation of any successful integrated care system. There must be clear mechanisms in place within any future system to ensure that the expertise of general practice is acknowledged and incorporated into healthcare systems at all levels. This will be essential for managing the growing shift of care into the community expected over the coming years, providing holistic and person-centred care, and contributing to tackling health inequalities.

9. Linked to the importance of a voice for general practice, the RCGP is also concerned at the lack of safeguards relating to resource allocation across the system. The proposal to put ICS on a statutory footing, absorbing all commissioning responsibilities, seems to put resourcing decisions solely in the hands of ICS providers large enough to be included in the ICS board. The current proposals would risk creating gaps within decision making, undermining the expertise GPs and impeding meaningful integration. The transformation necessary for implementation of the Long Term Plan will fail if resources are not sufficiently directed to support primary and community care delivery.

10. Systems must have clearer guidance and adequate safeguards to support this important strategic aim, and the RCGP will only be able to support these recommendations if these issues are addressed.

Principles to guide integrating care

11. On the whole, the RCGP concurs with most of the recommendations that were set out in the 2019 Health and Social Care Select Committee inquiry "NHS Long Term Plan: legislative proposals", which the proposals of this engagement build upon. In particular, we support the recommendations to revoke the Section 75 powers of the Health and Social Care Act 2012, which we assert have acted as a barrier to the development of new care models and collaboration between local NHS organisations.

12. The RCGP continues to be supportive of the broad aims of integration and the positive steps being taken to improve collaboration between different parts of the health and social care system. It is important to note that whilst we believe that integration will assist in relieving pressure on the system, it is unlikely to provide the uplift in capacity that is necessary to manage increasing demand. The integration agenda must be accompanied by additional real-terms investment and a coherent plan to grow the workforce.

13. The RCGP has previously outlined five tests for integrated care.[i] It is our view that proposed models of integrated care must:

    a. Ensure community-based services are led by community-based clinicians with a patient-centred perspective.

    b. Underpin safe patient care by ensuring that GPs can continue to act as independent advocates for their patients, with the emphasis on the patient not institution.

    c. Be patient focused, responding to the needs of the individual and protecting them from over-medicalisation, with GPs working with specialists to contribute to the holistic care of the individual.

14. In addition, it is equally as important that proposed models of integrated care do not:

d. Lead to major top down structural re-organisation.

e. Lead to the diversion of NHS funding away from general practice and primary care given their vital roles in delivering person centred care.

Timescales for integrating care

15. Legislative change that would establish ICSs as statutory bodies would require a fairly significant structural reorganisation for most systems, and this would be a major challenge if it is to be implemented in the timescale laid out. There are significant risks that the time required to establish these new bodies would divert focus away from service delivery and improvement work, particularly as the country recovers from the pandemic.

16. The RCGP would like to see a more cautious approach to ensure the changes do not create more problems than they can realistically solve. It is important that the idealistic aims of integrated care are tempered with a pragmatic view of what the health service can actually deliver within its capacity and resource constraints. The 2019 HSCSC inquiry agreed that, although establishing ICSs in law will eventually be necessary, the risks of legislating too soon outweigh the problems posed by the current challenges surrounding the governance and accountability of ICSs.[ii] It is important to ensure systems have a coherent roadmap, with stepping stones laid out in the legislation, to facilitate implementation without losing the progress many have already made.

17. This is even more important as the health service comes to terms with the fallout caused by COVID-19 - the true impacts of which are not yet known. The system-wide, collaborative response to the pandemic has been strong in many areas of the UK. While we believe there are significant learnings to draw on from these experiences, and certainly positive changes to be embraced, this has been a result of the response to a unique challenge. It would be unrealistic to expect the singular shared objective of fighting this virus can be used as the foundation for sustainable system transformation work as we move into the recovery stage.

The voice of general practice

18. The success of integrated care systems and the delivery of the Long Term Plan are not solely reliant on legislative change. Success will be determined by the relationships and collaboration of providers and the healthcare workforce within the system. A crucial element to this is a strong voice for general practice. There is clear evidence from around the world that a strong primary care service is a determinant of an effective and efficient healthcare system. Harnessing primary care has a health-promoting influence within systems, as well as being associated with more equitable distribution of health in

populations.[iii] The expertise of those delivering primary care must be at the forefront of healthcare design and transformation.[iv]

19. The proposed changes, and accompanying transformation strategy, make a clear attempt to maintain flexibility that allows local systems to shape their own structures according to local need. It is clear that a rigid, centrally decided structure that does not take regional variation and resources into account cannot be successful. It is also important to implement safeguards that ensure organisational scale is not the key decider in how influence is distributed throughout each system.

20. The RCGP has significant concerns that the proposals set out in this consultation do not have sufficient safeguards to ensure general practice is in a position to influence system priorities and strategy from the beginning and at the highest level. If this is not remedied, we believe that the transformation promised in the Long Term Plan will not be as successful as it could be.

21. An RCGP survey of 301 GPs on the proposals for next steps on integrating care, found that 12% said that general practice currently has a great deal of influence in their CCG, with 23% saying that general practice has a lot of influence. 43% of respondents felt general practice had a bit of influence in their CCG and only 15% respondents said that general practice had no influence at all in their CCG. This reflects the original objective of embedding a strong clinical voice in commissioning and strategic planning. [v]

22. This compares poorly to GP influence at the ICS/STP level. The same survey found that only 1% felt that general practice has a great deal of influence in their ICS/STP and 7% said that general practice has a lot of influence. 30% said general practice had a bit of influence. Crucially, 42% of respondents who thought that general practice had no influence in their ICS/STP. It must be a priority for all systems to engage general practice at the system level, to harness the skills and knowledge of GPs and their teams and improve care for patients. [vi]

23. Our survey showed that GPs had significant concerns that the different options for putting ICSs on a statutory footing would become dominated by secondary care interests and influence. These concerns were most significant in relation to the second legislative recommendation that ICSs be put on a statutory footing and absorb CCG responsibilities. 73% of respondents were very concerned that general practice influence would be reduced in the second option. This is compared with 52% very concerned about diminished influence should ICSs boards become statutory organisations and CCGs retain commissioning responsibilities.[vii]

24. Primary Care Networks (PCNs) are consistently mentioned as the unit for general practice within the proposals, as a building block that work together with other networks at the place level, then feeding up into the wider system. The RCGP is supportive of the development of PCNs, which we believe have significant potential to improve patient

access to a wider range of services, support additional staff into the primary workforce, enable better population health management, and improve patient outcomes overall.

25. However, PCNs are currently at varying stages of maturity, and while the proposals may be feasible for some, many PCNs are still in the process of developing and embedding collaborative working at the neighbourhood level. Many would find it particularly challenging to engage with system wide objectives, while also starting to deliver on new service specifications, building relationships between different practices, recruiting to new roles, stratifying local patient needs, finding space for new recruits and building a team and service across multiple providers. The RCGP would like to see PCNs afforded more time and resource to develop without piling on unnecessary pressure.[viii]

26. It would be more reasonable to support PCNs to develop into structures which can take on these system-wide roles over the coming years. This would need to include developing leaders within PCNs, which would need to entail securing additional resource for protected time for training and development, as well as system working. The latter is particularly important given the independent contractor status of practices, where backfill payments are required to support GPs in these roles. In the meantime, these proposals would need to make more realistic provision for systems to use established networks and system leaders that are currently based in general practice. Again, this must be supported by sufficient resource to ensure GPs are strongly represented in system roles, shaping services at a strategic level.

27. The success of integrated care will be determined by the relationships and engagement of the workforce. These must be given time and latitude to develop, and they must be built to include clinicians from across the sector, particularly those with generalist and population health perspectives. A transformation programme that does not recognise the importance of general practice cannot have a major positive impact on the health of our populations.

28. The effects of the pandemic have been felt across society, most acutely in deprived communities. A key benefit of the integration of care at the system level will be to bring health and care together to address these inequalities. GPs are in a unique position to provide insight across systems and communities. As medical generalists, they have a holistic view of the health of the patient, which is often not available to other specialists. GPs and their teams are well placed to understand their patient's experience, and routes into community, social and acute care. GPs are also often the first to become aware when major issues or barriers to care arise for patients in the wider system.

29. Wellbeing, morale, and efforts to retain the workforce will be particularly important as the health service emerges from the worst winter in living memory. Clinicians may feel less inclined or less able to continue working in a system that does not recognise their worth and expertise, or reduces the ability of the workforce to maintain a strong primary care system which we know is essential to the success of our healthcare system.

Systems must be better encouraged to harness general practice in recognition that a well engaged, adequately resourced primary care workforce is the bedrock on which the integrated care vision is built.

Resource allocation within integrated systems

30. The RCGP is supportive of the overall aim to devolve resource and decision-making to the most appropriate local level. Integrated care systems cover a variety of populations, providers and geographic areas, while local providers will have a better understanding of their populations' needs. GPs have the particular skills necessary to plan and deliver effective care for their patients.

31. The RCGP is concerned that there are not adequate safeguards within the proposals to ensure much needed and increasing investment in primary care. The RCGP has previously called for at least 11% of the overall NHS budget to be invested into general practice, and currently this is only at approximately 9.6%.[ix] This estimation does not include the fallout from COVID-19, which we expect to lead to a significant increase in capacity needed in primary care to meet growing patient needs - for example, the emergence of direct long-term effects of COVID-19, and increased waiting list times for many specialist services.

32. Investment in primary care over and above the ring-fenced baselines in national contracts is required to ensure the meaningful implementation of integrated care. As previously mentioned, a strong primary care service has been shows to improve the effectiveness and efficiency of healthcare systems.[x] Additional funding into primary care is also associated with savings in other parts of the system.[xi] There is a risk that resources allocated in a system that does not prioritise or understand the role of general practice will undermine the overall strategy contained in the Long Term Plan, such as promoting health and bringing care closer to patients' homes.

33. Analysis from the Health Foundation found that, although health policy has had a similar narrative about integration and reform for the last 20 years, there is little evidence to demonstrate that resource and service transformation has meaningfully followed.[xii] In order for service delivery to successfully shift upstream of health needs, those shaping services must have a qualitative, grounded, and ultimately frontline understanding of the work of GPs and their teams.

34. The RCGP would like to ensure that safeguards are in place to ensure system funding and the pooling of budgets are not used to make up for problems in other parts of health and social care. Without these, there is a risk that resources could be repurposed to powerful providers already in deficit, or to plug gaps in social care that should be supported by local government and/or additional funding from government.

35. The RCGP would like to see clarity on how GP influence and expertise will be embedded at all levels when making decisions relating to resource allocation. This will require dedicated resource and explicit encouragement within national and regional structures.

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