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

Sheffield LMC

We note a few overriding issues when considering our response to this document:

- Service rearrangement should be to improve patient care or, as a minimum, not to detract from patient care.
- Patients value local services, particularly from their GP surgery.
- Continuity of care can actually reduce the requirement for hospital services: https://www.bmj.com/content/356/bmj.j84
- Larger GP surgeries reduce continuity of care.

We have also approached review of this document from the basis of general practice. Our key considerations are, therefore:

- The impact on the patient;
- The impact on patient services (procurement and delivery);
- The impact on general practices and the partnership model;
- The impact on primary care;
- The impact on Primary Care Networks (PCNs);
- The impact on place-based primary care delivery models.

Whilst we recognise that this is a "High-level" document, we must not lose site of the purpose that we all serve - to improve health and social care of patients whilst also promoting a preventative agenda.

The Patient and Patient-facing Services

We are concerned that this document does not consider the impact these organisational changes might have on patients and service delivery. It is notable that decision-making will move further from the patient under either proposed option. The dissolution of "Place" CCGs and replacement with a single CCG, or direct commissioning powers by the Integrated Care System (ICS) Statutory Body isolates local decision-making.

S1.8 proposes the devolution of more functions to local level but devolution process will still be under the management of the ICS.

We welcome the proposal in 1.15 for a preventative agenda and this will require considerable collaboration between organisations and general practices. Some of this collaboration will need to be at "Place" level but also at local community level to reflect variations across the city. This will require considerable leadership and representation from general practice.

We highlight the need for local decision-making on local needs. There is a granularity to providing general practice and primary care services to small populations that recognises the differences between communities within a city. Recognising this and maintaining continuity of care can reduce hospital costs. This requires the recognition and support to organisations delivering these services.

This "Integrating care" document says nothing to support this granularity and organisations such as general practices delivering this vital care. Expanding the base-unit of general practice to PCNs, as this document conflates the two, will lose continuity and increase costs.

Local commissioning of some description, with intimate knowledge of the local population differences, is required to recognise these differences in communities and respond accordingly. This will only improve services to our patients and outcomes for our patients if general practice is involved. The removal of locally led CCGs with GP involvement is a step away from this and, ultimately, a detriment to our patients unless it is replaced with significant Place and ICS involvement.

General Practice and Primary Care

There is no discussion in the "Integrating care" document about general practice, where 90% of NHS patient contacts occur. There is also the misunderstanding that general practice and primary care are one and the same - they are not. General practice is a vital element of primary care.

Discussions about vertical and horizontal integration (2.5) make the suggestion that general practice should be "integrated" into other services rather than collaborate with them. This challenges the notion that NHS England and NHS Improvement (NHSE/I) support the partnership model of general practice, as they have claimed and are trying to promote their previous "Multispecialty Community Provider" (MCP) model by a different route. This fails to recognise the unique and important position general practice has played since the inception of the NHS and its future role. It also fails to comprehend the significant community estate held and managed by GPs. GPs are also direct employers of a significant number of staff, much more than through the Additional Roles Reimbursement Scheme (ARRS) of the PCN Directed Enhanced Services (DES). This too is not acknowledged or addressed in consideration of "integration".

Co-ordinating approaches to recruitment (2.15) have started through workforce hubs with practice nurses and physician associates. Developing and training for these skills is necessary for the expanding work force in primary care. However, it is not clear how employment models across the system (2.16) would affect GPs. Again this is a threat to the independent contractor model.

PCNs

The proposals do not recognise the fundamental basis for PCNs. They are an agreement for general practices to collaborate on certain projects. They are not an entity in themselves, and require the continued co-operation and sign-up of the constituent practices. The PCN DES is an optional contract for practices to sign and deliver and requires confirmation each time there is a change to the requirements. The "Integrating care" document conflates the two and so fails to recognise the importance of general practices, which may decide not to continue with the PCN model in its current format if the practice service delivery is considered by the ICS as inferior to the PCN DES.

The vast majority of general practice is conducted by individual practices, with only very small amounts of activity at PCN and "Place" level. There is a failure to recognise this either in the discussion of service provision, representation or leadership.

Whilst the rhetoric is inexorably to provision at scale and integration this fails to recognise the importance of general practice level provision to the community or aiming to reduce workload on secondary care.

Leadership and Representation

These are two different entities and are entirely dependent, in general practice, on the practices themselves.

As discussed above, the vast majority of medical care in the community is delivered by GP practices. They agree or not to collaborate on a small amount of care through PCNs, and some activity is better delivered at scale through federations. Representation should, therefore, reflect where the vast majority of work lies and this should be both at local "Place" level and at the ICS. PCN Clinical Directors do not represent the vast majority of work delivered in general practice or primary care, and are employed in a service delivery role, not a representative role.

Federation leads, Local Medical Committees (LMCs) and Clinical Commissioning Group (CCG) commissioners represent general practice in different ways, and there needs to be recognition that all are important in shaping future services after this re-organisation. The dissolution of CCGs as GP membership bodies will obviously have a significant effect on this balance.

Conclusion

We do have serious concerns about some of the proposals in this consultation document, not least the transfer of commissioning responsibility from "Place" and making it more distant from local issues. The mention of devolving more functions to "Place" is welcomed but comes with caveats about shared budgets, vertical and horizontal integration. These do not fit with a nationally negotiated core general practice contract.

We also welcome increased focus on a preventative agenda and tackling health inequalities; both are prime areas for local collaboration and GP leadership.

The proposals need to consider "bottom" up development of services as a solid GP base will lead to solid PCN delivery etc. Top down imposition and more distant commissioning will not lead to better outcomes.

In terms of the questions asked in the document, the above discussion would lead us to these answers:

Q. 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? **No, it moves decision-making too far away from local needs.**

Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients? **No. Some form of local "Place" based commissioning will better meet the needs of local populations, perhaps with more focus on areas of collaboration.**

Q. 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? **Yes.**

Q. 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? **Yes, but there need to be sufficient safeguards to nationally agreed contracts and funding streams.**