Response ID ANON-9K5H-J8J8-5

Submitted to **Your views: building a strong, integrated care system across England**
Submitted on **2021-01-07 10:56:27**

Integrated Care System (ICS) legislation

1 What is your name?

Name:
Simon Barrett

2 In what capacity are you responding?

In what capacity are you responding?:
Other (Please specify below)

If you have selected 'Other', please specify::
CEO of Humberside Local Medical Committees - we represent 650 GPs across the Humber

3 Are you responding on behalf of an organisation?

Yes

Organisation name::
Humberside LMCs

Email::
humberside.lmcgroup@nhs.net

4 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?

Disagree

If you have any specific comments or additional information to provide, please provide it in the text box below::
The proposals which form the subject of this consultation will drive a substantial extension of the role of integrated care systems, with the planning, commissioning and organising of services moving to this level. The options set out will see a fundamental change to the way primary care is organised and its funding allotted. It is our view that General Practice has been inadequately involved in the development of the proposals and the design of the consultation. Specific requirements are in place for any consultation that involves significant changes to service delivery including that the consultation should allow adequate time for consideration and response and should be proportionate to the type and scale of any potential impacts of the proposal decision being taken. We do not consider that these requirements have been met in relation to this consultation.
The timing and scope of the consultation has been very poorly judged. Carrying out this consultation both during a pandemic and over the festive period limits the opportunity for frontline clinicians to provide their views and significantly reduces the quality of this engagement exercise and undermines trust in the process. Given the enormous pressures and multiple demands to which General Practice is currently subjected, an insufficient response period and narrow scope of questions has been provided and we would request that the response period is extended by at least eight weeks.

5 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?

Strongly disagree

If you have any specific comments or additional information to provide, please provide it in the text box below::
The models proposed do not represent a robust or meaningful review and presentation of options available for what will be a hugely significant change for the delivery of primary care generally and for general practice in particular. There is also clear bias towards option 2 in the paper and in the questions included in the scope of the consultation.
Points of particular concern include:

• It is our view that at this stage there exists limited opportunities to influence the debate and change the outcome of this consultation or operational direction of travel. Our evidence for this is the limited period of time available to respond and the narrow range of questions and options presented.
• General practice /PCNs/CCGs/LMCs need assurance that they will have the opportunity to engage and influence any proposed models and subsequent drafts in a meaningful way.
• The proposed models suggests a departure from the GP led commissioning model which implies a loss of focus on community and primary care at the heart of healthcare.
• Neither of the proposed legislative changes reassures us that ICSs will be clinically led. A strong clinical voice is essential for the success of an ICS.
• There is significant concern about the minimal detail about general practice and primary care throughout the document.
• We have serious concerns about how the GP voice could be equitably represented on ICS boards. Our concern is it would replicate the imbalance currently experienced with interface & recovery groups, pathway groups, managing secondary care waiting lists, where secondary/primary collaboration is one sided and dominated by secondary care. True collaboration empowers all parties, is balanced and provides an equal voice for those involved. As 90% of patient contacts with the NHS are with primary care it is essential that there is a strong clinical GP voice within the ICS. The present system and the proposals outlined in the

document fail to provide this clear, strong voice for GPs. There should be a leading role for primary care clinicians and proper representation within all ICSs and their substructures (i.e. Place), including formalised roles for LMCs as representatives of provider GPs. We seriously question whether any reduced role or influence for General Practitioners can be in the best interests of patient care.
• Local Medical Committees are the unifying voice of the General Practice profession and must be represented in any statutory ICS structures.
• Reference is made to adoption of a payment system which will move funding away from activity-based payments and ensure a majority of funding is population-based, however there is no clarity with respect to how ICS funding will be governed, allocated and flow to providers. This is needed in order to understand the system dynamics and drivers.
• Significant concerns have been raised in regards to Funding as outlined in the proposals and that it contains insufficient detail and provides little evidence of informed understanding of how the independent contractor model of General Practice operates and is funded. Many questions about whether funding for primary care will be ring fenced, will flow as it does currently to practices and PCNs directly or run through the ICS first or be utilised to support other voids within the system such as secondary care have been raised. General Practice is funded through the GMS/PMS contract. The consultation document does not give detail of whether or not GMS/PMS funding is included in the “single pot”. This needs to be specified in any proposal, and negotiated with the General Practitioners Committee (GPC) of the BMA, before any proposed changes can be considered by the profession.
• If PCNs were to take on a greater delivery and commissioning role it is not clear that they will have the resources, skills or infrastructure to effectively deliver this. PCNs remain relatively immature organisational structures and with the current investment trajectory they are unlikely to be consistently delivering what will be required in terms of population health management by April 2022.
• Primary Care Networks (PCNs) do not have legal or statutory basis, they are collaborative collections of general practices. PCNs should be represented within ICS structures, alongside the statutory representative bodies of General Practice, the Local Medical Committees.
• The positive key elements of CCGs such as a strong clinical voice, local decision making, and accountability that can support any new model could be helpfully retained.
• We are concerned that passporting of staff across the health system could drive the end of independent contractor partnership model in primary care.
• Our members are concerned that the “Integrating Care” document seeks for services to be tailored to the neighbourhood level driven by local need but at the same time a contradictory mandate that all services must be equally accessible to the entire population of England.

6 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?

Strongly disagree

If you have any specific comments or additional information to provide, please provide it in the text box below::
The “Integrating Care” document suggests that decisions taken closer to the communities they affect are likely to lead to better outcomes. Supporting local governance arrangements would allow local decision-making about health outcomes to emerge, but only where all collaborators have an equal voice and access to funding and resources. The transition to this system from the current imbalance in favour of larger, more dominant providers would be prejudicial to the independent contractor model of General Practice, risk further dilution of the Partnership Model and disenfranchise many GPs.
Primary Care, and General Practice in particular, performs ninety per cent of the clinical contacts of the NHS, and must, therefore be part of the formation of ICS’s, have statutory representation within all ICS structures and be supported by LMCs. If this is left to local determination this could risk under-representation of this vital section of health providers.

7 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?

Neutral

If you have any specific comments or additional information to provide, please provide it in the text box below::
The “Integrating Care” document talks about “Delivery [which] will be through NHS providers, local government, primary care and the voluntary sector working together in each place in ICSs, built around primary care networks (PCNs) in neighbourhoods.” This implies a focus on PCN population size commissioning as a true solution to population health problems. A very significant transfer of governance, funding, skills, estates and resources will be needed into Primary Care Networks, at an unprecedented pace, to achieve this by April 2022.
Current experience of the design of more integrated patient pathways horizontally across providers and vertically within local place-based partnerships exposes clear fault lines in how this is achieved collaboratively. A step change in the process for collaboration with strong leadership and precise governance is essential if any future collaborations are to achieve this desired outcome.
We are concerned that where larger providers choose to use their scale to host functions on behalf of other system partners, this will negatively impact on the population based agility of decision making available to General Practice.
The ability of primary care to respond rapidly with altered consulting models, and most recently vaccine deployment during the pandemic has been in stark contrast to the slow changes by secondary care to address waiting lists and manage patients based on clinical need. Delegation or transfer of any commissioning should have due consideration of how to retain this level of responsiveness especially at a time when the whole system is under enormous pressure with a legacy effect from COVID.
A move away from nationally mandated initiatives, multiple and confusing outcome based funding pots, towards an ICS and place freedom to truly fund and respond to population needs would be welcome.