Integrated Care System (ICS) legislation formal feedback

1) What is your name?

Name: Dr Brian McGregor (GMC 3266045)

2) In what capacity are you responding?

Medical Secretary, YOR Local Medical Committee Limited (YORLMC)

YORLMC is the brand name for Bradford & Airedale and North Yorkshire LMCs. It is the professional voice for all NHS GPs and practice teams across the areas of North Yorkshire & York and Bradford, Airedale, Wharfedale & Craven.

YORLMC represents c150 practices across 30 PCNs with multiple sites and approximately 1600 GPs with countless team members providing care for a patient population of c 1.5m

YORLMC has a reputation for a positive, collaborative style of working to achieve the best outcomes for its members.

3) Are you responding on behalf of an organisation?

Yes
Organisation name: YOR Local Medical Committee Limited (YORLMC)
Email: info@yorlmcltd.co.uk

We welcome the proposal to make ICSs a statutory body, as we feel that to date their development has lacked transparency with little or no involvement of GP providers in an effective way. This has led to an inherently discriminatory and inequitable situation. We believe that a more inclusive, transparent and collaborative system would produce significant progress in population health and managing local inequalities in care, with improved productivity.

We believe the current ICS development gives undue status and influence to acute, community and specialist trusts, and remain concerned that some of the proposals within the transformation document could perpetuate that situation. This will hinder collaboration going forwards.

We have significant concerns with regards to the clarity of how a clinical voice will be maintained in either option, particularly a truly Representative voice of General Practice. However, our concerns also extend to how are other clinical colleagues throughout primary and secondary care will be involved in any future structure of an ICS.

There is a lack of commissioning clarity particularly with regards to current General Practice GMS & PMS contracts, where these will sit, who will influence and govern them, and how they will be developed and extended going forwards.

The concept of a single financial pot represents a significant threat to the future of the independent contractor model of General Practice. Whilst no other members of the ICS will face personal financial risk, GP Partners will, given the link between the financial regulations attached to the independent contractor model and the requirement for personal financial liabilities. It is also important to recognise that the independent contractor model has served the NHS well since inception; the independent contractor model delivers incredibly efficient, effective care at high volume and low cost. This General Practice funding model is unique and cannot be rationalised with other NHS funding streams coherently.

Staffing and capacity issues must be understood. It is our belief that many existing partners in care are not sighted on the current pressures relating to workload and workforce in General Practice. To provide care closer to patients will involve a significant shift in mindset with regards to resource investment into primary, community and social care. It is not clear that this will be achievable with the proposed structures likely to be dominated by secondary care trusts.

There is a lack of clarity as to how accountability will be dealt with particularly within option two, and how governance will be dealt with in a collaborative fashion through the ICS.

Whilst the ambition of more highly integrated and collaborative services is a commendable ambition, there is little detail on how this will be achieved on integrating social and healthcare with paid for/free services, how budgets will be managed, and staff provided. This will also impact on the proposed boundaries which within the document are suggested will be based on Local Authorities. Currently these are not coterminous with PCN boundaries. There therefore needs to be a clear definition of how the population to be cared for will be defined.

Provider collaboratives will only be successful if each provider has autonomy in electing/selecting their leadership. In General Practice there is already a statutory Representative organisation in the Local Medical Committee, which is a democratically elected group.

There is significant disappointment LMCs are not mentioned at all within the document, and any structure that excludes democratically elected representatives would be inappropriate.

We would suggest considering joint LMC and PCN representation at neighbourhood and place level, with LMC representation at ICS level. PCNs which are promoted throughout the document are still comparatively young organisations that in our areas are working effectively and collaboratively with the LMC in providing a robust voice for general practice. They are organisations without a legal or statutory status, and currently work as a collaboration of general practices. It may be they will develop with time, but currently they would not be seen to speak at place or ICS level on behalf of General Practice. The same would be said of federations, and CCG appointed clinical leads. If ICSs are to be successful as a true provider collaborative, they will need to get their membership right from the outset or risk disenfranchising a group that provides 90% of all patient contact within the NHS.

The timing of this review and request for feedback is considered to be completely inappropriate. It was launched during the final week of November 2020. The following week general practice commenced on the biggest vaccination programme this country has ever tried to deliver. Almost all primary care networks, LMCs, and other leads in the primary care environment have been distracted and overloaded in an attempt to ensure the safety of our patients. We feel this is undermined the process, will lead to it being not inclusive and almost certainly discriminatory, and that would be virtually impossible for most leaders in general practice to respond an effective manner and productively. As such we would strongly recommend that the period for feedback as extended to allow an appropriate response from general practice going forwards.

In answer to the specific questions in the consultation document:

Whilst we agree that ICSs should progress to a statutory footing, we do not agree with either of the options proposed, due to a lack of clear clinical leadership in either proposal, a lack of definition as to what will happen with commissioning of general practice and its funding, and the lack of recognition of the statutory Representative body of General Practice.

We do not agree that option two provides a greater incentive for collaboration and accountability, as there is no clear clinical voice and leadership, meaning there is no direct feedback between patients and commissioning decisions.

We do not agree that the proposals should allow systems to shape their own governance arrangements, the definition of using NHS bodies, allows a mandatory place to acute trusts and community trusts, but the paper and proposal specifically suggest that General Practice could be excluded, and other primary care representatives used to replace them. As stated previously 90% of all patient interactions take place within General Practice and if anything they should have primacy of place in comparison to other providers.

We do not agree that services currently commissioned by NHSE should be transferred or delegated to ICS bodies, there are certain specialist services, which are so small in number they need to be appropriately commissioned on a national basis such as transgender and eating disorders services in children, and these would sit across ICSs similar to ambulance services and some other mental health services. Relaxation of those current commissioning structures could potentially lead to a much lower standard of service based on cost rather than quality. It would be much better for NHSE/I to continue to commission the services on a regional basis.

06 January 2021