Written evidence submitted by The Royal College of General Practitioners (ICS0029)

The Royal College of General Practitioners (RCGP) welcomes the opportunity to respond to the Health and Social Care Select Committee inquiry into how Integrated Care Systems will deliver joined up health and care services that meet the needs of local populations.

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

The most important aim for any NHS reform should be to improve care for patients. In introducing ICSs, the government committed to a new way of envisaging our health system - a bottom-up approach built around patient need. A core aim was to build flexibility into the system to allow service providers to collaborate according to the needs of their local populations.

The right balance must be struck between high-level oversight and planning, to support integrated care, and flexibility at the local level to serve population needs. In the face of the crisis in general practice, it is essential that this balance continues to prioritise what will most benefit patient care, and this must include ensuring that GPs and their teams can provide strong representation for their patients as part of these reforms. In our submission below we set out which areas we believe ICSs need more regulation or guidance, areas where they need flexibility, and where decisions will still need to be taken at a national level.

Within those points some of our key recommendations are:

- Every ICS needs to find a way to guarantee that the voice of primary care and general practice is not lost with the abolishment of CCGs.
- ICSs should undertake comprehensive and transparent workforce planning to respond flexibly to changes in their area including how they can support primary care.
- With four in ten GPs saying that they are planning to quit the profession in the next five years, every ICS needs to provide structured support to practices to design and implement localised and tailored retention schemes to help ensure GPs remain in post and have long, fulfilling careers.
- ICSs should be required to deliver regular estate planning and reporting for primary care.
- There is no point removing bureaucracy at the national level just to reintroduce it again at ICS level; where possible, central performance targets should be avoided.
- To help to mitigate a "postcode lottery", funding decisions for core general practice services should continue to be negotiated at the national level, with geographical and socio-economic disparities taken into account, rather than become the responsibility of ICSs. However, ICSs should have the flexibility to target additional funding into general practice services where this will improve patient outcomes and support staff.

Areas that ICSs need more regulation and guidance

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 general practice 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 should not dip into clinical delivery areas that are more appropriate for PCNs and service providers who are actually delivering the work.

We recognise some areas where regulation of ICSs will be necessary to deliver a functioning and integrated health service:

A stronger voice for general practice

There is considerable evidence that a strong primary care service is a key determinant of an effective and efficient health service.[i] A strong GP voice provides perspective on the patient experience and is invaluable for delivering integrated care at all levels of the system.

At present, Integrated Care Boards (ICBs) are required to have at least 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. Compared to Clinical Commissioning Groups (CCGs), the boards of which were made up primarily by GPs and other clinicians, this is a significant loss of the clinical voice at the system level. This loss will have ramifications for the types of interventions that are designed, the direction of resource allocation, and the ability of primary care to push back against priorities of the much larger NHS Trusts.

The new Health and Care Act places NHS trusts and foundation trusts in a privileged position in deciding on how plans are made and resources allocated. The law says that when Integrated Care Boards prepare their five-year work plans and their capital plans, they need to do so with their "partner NHS trusts and NHS foundation trusts". Primary care is not included in this consultation, and as a result is being left out of key conversations in the system.

ICSs should be mandated to ensure that primary care leadership - including those working within general practice - is embedded in the system at all levels, and have an equal voice in Integrated Care Systems. This could look like the creation of a primary care forum, as suggested by the Fuller Stocktake, and leadership pathways that incorporate protected time to develop GP leadership within the system.

Workforce planning and retention strategies

The NHS cannot deliver the care patients need without the workforce to deliver it. However, demand for general practice continues to outstrip supply. From 2015 to 2020, the UK population grew by 1.97 million;[ii;iii] from 2015 to 2022, the number of full-time equivalent fully-trained GPs fell by 424.[iv;v] As of April 2022, each GP looked after 2,056 patients on average - a 10% increase since 2015.[vi] On top of this, our 2022 survey of RCGP members found that 42% of respondents in England were considering leaving the profession within the next five years.

In the face of this crisis, we need targeted intervention at all levels of the system. As part of our Fit for the Future campaign, we have already called for a national retention fund of at least £150 million annually for GP retention and career development programmes, plus additional funding for practices in the most deprived populations to recruit and retain staff. ICSs are best placed to support delivery of these schemes.

ICSs should undertake comprehensive and transparent workforce planning to respond flexibly to changes in the workforce and ensure primary care is adequately supported to function. This should include proactive work to expand and integrate multidisciplinary teams to manage workload pressures

experienced by GPs. As we experience growth in the number of trainees, it will also be crucially important that ICSs support training capacity to ensure the workforce has capacity to grow.

ICSs should also be required to ensure practices and networks have the resources and support they need to design and implement localised and tailored local retention schemes to help ensure GPs remain in post and have long, fulfilling careers. ICSs should be required to review and showcase the local initiatives in a supportive way for practices.

Previously, CCGs could decide whether or not they would approve funding for access to the National Retention Scheme, and as a result as of May 2022 about a quarter (20 of 86) of CCGs in England did not.[vii] As of June 2022, one ICS did not report having any GP retainers.[viii] We view that this opt-in policy is unacceptable for ICSs given the substantial pressures on general practice at present.

Ensuring premises are fit for purpose

In our latest RCGP tracking survey of 1262 GPs, 74% said their practice did not have sufficient physical space to accommodate new staff. 64% said their computer systems were not able to properly share information with hospitals, and 34% said the IT for their booking systems is not good enough. As we move towards a more joined-up approach to working across health and social care, more attention will need to be given to designing both physical and IT pathways across the system and ensuring premises are adequately fitted to deliver increasing types of patient contact.

ICSs should be required to deliver regular estate planning that both looks at the existing estate landscape, taking on opportunities to repurpose and upgrade existing premises, and that plans for future community needs and more dynamic ways of working. This should include making sure basic facilities (such as telephony and booking systems) are up to date and efficient, existing facilities are decarbonised in line with the NHS's aim of being carbon neutral by 2045, and focusing investment on premises in deprived areas where there is greater community need. There should be clear lines of accountability for delivery of this estate planning, and systems held accountable for standards of premises within their remits. However, to require this level of accountability at ICS level must also require responsibility. There must be adequate support and flexibility from central government to support the ability of ICSs to lead this planning at the system level, and sufficient funding to achieve decarbonisation goals.

Support for practices in deprived areas

Ensuring equity of access to health services and focusing care where it is most needed is a necessary focus for ICSs. We welcome the duty on ICBs to reduce patient inequalities, both in terms of access to services and health outcomes, and to promote integration where this would reduce inequalities. For the most part, we believe that flexibility should be built into this duty to allow ICSs to reduce inequalities from the ground up.

However, in areas with more deprived populations, delivering equitable health outcomes will require greater support from central sources. On average, general practices serving more deprived populations receive around 7% less funding per patient than those serving more affluent populations. In addition, a GP working in a practice serving the most deprived patients will on average be responsible for the care of almost 10% more patients than a GP serving patients in more affluent areas.[ix]

In order to reduce health inequalities, the system needs to support these practices to deliver the best possible care. ICSs should be held accountable for the performance of the practices they have oversight of; struggling practices should be supported into development programmes and targeted interventions should be implemented to improve the quality of care they provide. Pathways should be designed that

recognise downward trajectories in practice performance and intervene before they find themselves in places of hardship.

Areas where local flexibility is crucial

While we have called for many areas in which ICSs should be regulated in order to deliver improved care for patients and improved system planning, we are aware of the risk of introducing too much regulation at the system level. ICSs should be able to accommodate local needs, address population differences, and enable innovation and autonomy at the practice level. Too much regulation, especially that which requires action from individual practices or GPs, will take clinician time away from patients and increase unnecessary levels of bureaucracy.

The right balance needs to be struck between high level planning and devolving decisions to a level that empowers grassroots staff. Where possible, the autonomy to use skills and resources to deliver a service should sit with the entity delivering the service; for most clinical decisions, this is at the practice level.

The College recognises that high-trust, low bureaucracy models for resource allocation have been effective in the past, and that aligning funding with meeting certain criteria or 'tick-boxes' does not promote best practice in patient care. 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.

There are particular areas that in our view should be built with more flexibility, to enable general practice to best serve patients:

Minimising performance targets

General practice is already subject to a vast swathe of targets through the Quality Outcomes Framework (QOF) and Care Quality Commission (CQC) regulation. Any additional targets that are introduced at the ICS level should be evaluated carefully according to the consequences on an already-stretched primary care system. There is no point removing bureaucracy at the national level just to reintroduce it again at ICS level; where possible, central performance targets should be avoided.

Where targets are necessary, they should be outcomes-based. Measurement of progress should recognise improvements to services rather than achieving strict clinical criteria that are not necessary in all cases. Local systems should be empowered to design their own plans to reach targets that work for their populations and are responsive to changes in workforce, estates, structure, and integration. Funding should not be reliant on achieving piecemeal targets, but should be provided to support systems to progress towards improving patient outcomes.

Inequalities planning and population health

A whole-system view needs to be taken to population health and inequalities planning to improve outcomes for the most vulnerable. While we believe that it is crucial that systems are held to account for their progress in improving outcomes, we also believe schemes that are designed by and for local populations have the best success. Central targets to address health inequalities and design population health interventions should allow local systems the flexibility to work with their populations to design schemes that address their particular needs.

Areas that need decision-making at a national level

Some decisions should not be delegated to ICSs, but instead continue to be held at the central level. In other words, central government should continue to remain accountable in these areas.

The overarching funding and contracts for general practice

Funding decisions for core general practice services should continue to be negotiated at the national level, and should not be the responsibility of ICSs. There is a risk that devolving core funding decisions to the system level could result in worsening a "postcode lottery" that currently disadvantages practices in more deprived areas. However, local systems should be able to target additional funding into general practice services where this additional investment will improve patient outcomes, patient experience, maximise return on system investment and enhance clinician experience - the latter being key to maintaining a sufficient workforce.

National workforce planning

Although ICSs should undertake workforce planning for their regions, they do not have the scope or perspective to undertake planning that will deliver on the needs of the growing national population. As GP numbers continue to fall, workforce planning at the regional level will be insufficient to address the significant challenges to come.

During the passage of the Health and Care Act, the College called for clearer reporting structures from central government on workforce planning and the establishment of an independent NHS workforce planning body. We will continue to call for central government to do more to ensure the healthcare system has the workforce it needs to meet growing demand and tackle health inequalities.

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[i] WHO. (2018). *Building the economic case for primary health care: a scoping review.* Available at: https://www.who.int/docs/default-source/primary-health-care-conference/phc---economic-case.pdf

[ii] Office for National Statistics. (2015). *Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2015.* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2015

[iii] Office for National Statistics. (2020). *Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2020.* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2020

[iv] NHS Digital. (2021). *General Practice Workforce, 31 December 2021.* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/31-december-2021

[v] NHS Digital. (2022.) *General Practice Workforce, 31 May 2022.* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/31-may-2022

[vi] RCGP analysis of NHS Digital appointments data and NHS Digital General Practice workforce data

[vii] NHS Digital (May 2022). General Practice Workforce.

[viii] RCGP analysis of NHS Digital (May 2022) General Practice Workforce.

[ix] The Health Foundation. (2021). *'Levelling up' general practice in England: What should government prioritise?* Available at https://www.health.org.uk/publications/long-reads/levelling-up-general-practice-in-england

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