Written evidence submitted by Royal College of General Practitioner

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

Integrated Care Systems (ICSs) are being asked to deliver significant changes to the way health and social care work in England, and they are a core piece of the NHS's long-term plan. The vision proposed by the Fuller stocktake this year shows that ICSs will in particular have a key role in the development of the future delivery of primary care.

The current pressures in the healthcare system, and the additional asks that are continuously arising for ICSs, are significantly limiting their ability to establish themselves in an effective way. Some of the establishment actions required for an effective ICS, such as developing collaborative links across the system and properly designing patient pathways, are dependent on ICSs having the resources and headroom to undertake them. In the current operating environment, they do not.

In addition, external pressures - such as shifting levels of investment, national workforce shortages, and a turbulent financial environment - continue to limit their ability to establish, and will further impact their ability to deliver on their stated goals.

The legal design of ICS could also make it harder for ICSs to improve primary care delivery. We have moved away from a system where CCGs provide a strong voice for primary care to one where there is a danger that large acute hospitals could potentially dominate decision making. The agreement by all ICS leads to engage with the Fuller stocktake may help counteract this problem, but only if every ICS prioritises engaging with primary care representatives in there area and puts resources in place to do this effectively.

As it has only been three months since their formal establishment, we cannot say whether ICSs will achieve their core objectives. However, we believe that additional resource, and expertise could allow them to do so.

Our key recommendations are:

1. Every ICS needs to find a way to guarantee that the voice of general practice, alongside the wider primary care, is not lost with the abolition of CCGs.
2. 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.

3. ICSs should undertake comprehensive and transparent workforce planning to respond flexibly to changes in their area including how they can support primary care.
4. 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 becoming 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.
5. 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 initiatives to help ensure GPs remain in post and have long, fulfilling careers.
6. ICSs should be required to deliver regular estate planning and reporting for primary care.

Improve outcomes in population health and healthcare

ICSs have been designed to improve outcomes in population health through supporting integrated care and enabling better patient pathways through the system. In theory they could provide a stronger population health focus than CCGs, but their ability to deliver on this will rely on their ability to maintain this focus in the face of many other competing pressures from politicians and the public, as well as the outcome measures that are used.

We believe some aspects of how ICSs are being established are undermining their ability to focus on outcomes for population health and healthcare:

1. A reduced voice for general practice
2. Excessive targets
3. Insufficient workforce

1. A reduced 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 and is associated with better population health.[i;ii] 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 within ICSs. 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.

At present, ICSs are not 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. Embedding the voices of general practice and other parts of primary care in ICSs, could look like the creation of a primary care forum, as suggested by the Fuller Stocktake, as well as leadership pathways that incorporate protected time to develop GP leadership within the system.

Recommendation 1: Every ICS needs to find a way to guarantee that the voice of primary care and general practice is not lost with the abolition of CCGs.

2. The danger of excessive targets

The healthcare system is already subject to a vast swathe of targets, which are growing all the time. Each additional target diverts time, focus, and resources from core goals, often without delivering tangible improvements to health and care. We are concerned that ICSs may become subject to politically-driven targets that will reduce their focus on population health.

Any additional targets that are introduced at the ICS level should be evaluated carefully according to the consequences on an already-stretched 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.

Recommendation 2: 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.

3. Insufficient workforce

The NHS cannot deliver the care patients need as well as help improve outcomes in population health without the workforce to deliver it. Demand for general practice continues to outstrip supply. From September 2015 to August 2022, the number of patients has grown by 4,949,000, a 9% increase. [iii;iv] but in the same timeframe, the number of full-time equivalent fully-qualified GPs fell by 1,850.[v;vi] On average, as of August 2022, each GP looked after 2,248 patients - a 16% increase since 2015. [vii] Our

2022 survey of RCGP members found that 39% of the GP workforce across the UK are seriously considering leaving the profession within the next five years.

To ensure they are able to achieve the objective of improving outcomes, in the face of a growing workforce crisis, 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 effectively integrate multidisciplinary teams to manage workload pressures experienced by GPs. As we experience growth in the number of GP 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.

Recommendation 3: ICSs should undertake comprehensive and transparent workforce planning to respond flexibly to changes in their area including how they can support primary care.

Tackle inequalities in outcomes, experience, and access

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.[viii] 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.

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. Systems should be designed that can identify downward trajectories in practice performance at an early stage and intervene before they find themselves in places of hardship.

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.

Recommendation 4: 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.

Enhance productivity and value for money

ICSs need sufficient upfront funding to allow them to develop the systems that will be productive and cost-effective in the long run. Any change process, especially at the scale and with the resource constraints of health and social care, will require upfront funding. Furthermore, many ICSs are carrying historic deficits and operating in financially constrained environments, yet being asked to develop significant new ways of working. This approach is unlikely to be successful without additional support and resource for transformation.

We believe investment is needed in the following areas:

1. Change management resource

The shift from traditional models of healthcare provision towards new models of integrated and multidisciplinary care - let alone the additional transformation suggested by the Fuller stocktake - will require significant organisational support at all levels of the system.

No other sector would expect to achieve the degree of change required of the health and care sector without investment in change management support. We are concerned that, without sufficient investment in leadership and management capacity, ICSs will not be able to deliver the significant change required of them. In addition, the lack of a systematic and planned transition towards new ways of working is likely to amplify costs and productivity inefficiencies.

2. Retention schemes

It is significantly more cost-effective to retain existing staff than to train and develop new staff. As part of our Fit for the Future campaign, we have 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.

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.[ix] As of June 2022, one ICS did not report having any GP retainers.[x] An opt-in policy is unacceptable systems given the substantial pressures on general practice at present, and all areas should ensure they have availability for GPs to access a national scheme, if GPs are at high risk of leaving general practice.

Recommendation 5: 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.

3. Infrastructure

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. With the move towards a more joined-up approach to working across health and social care, more attention should 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, to help enhance productivity.

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. There must also 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.

Recommendation 6: ICSs should be required to deliver regular estate planning and reporting for primary care.

Help the NHS support broader social and economic development

Primary care is essential to the healthcare system, and the healthcare system is essential to broader social and economic development. If they work effectively, ICSs could provide networks of health and social care that keep people healthy and in work, build social and community links, and encourage investment in healthier environments.

Given their early stage of development, it is difficult to say whether ICSs are likely to deliver such a significant goal. Their ability to deliver will be dependent on many of the other recommendations in this response.

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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] Kringos, D. S.; Boerma, W.; van der Zee, J.; Groenewegen, P. (2013). *Europe's Strong Primary Care Systems Are Linked To Better Population Health But Also To Higher Health Spending.* Available at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2012.1242

[iii] 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

[iv] 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

[v] 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

[vi] 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

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

[viii] 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

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

[x] RCGP analysis of NHS Digital General Practice Workforce.