Written evidence from Royal College of General Pratictioners (PCC0033)

HOUSE OF LORDS INTEGRATION OF PRIMARY AND COMMUNITY CARE SELECT COMMITTEE INQURY

Integration of Primary and Community Care Committee Lords Select Committee: RCGP written evidence submission

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Introduction and summary

General practice acts as the point of access for many community services. Our members know that when practices work closely with the other local care providers, patient care improves. But GPs also see significant barriers to integration caused by the way the NHS and other services are arranged and funded.

The RCGP Fit for the Future report in 2019 set out a vision for general practice that included better integration with community care[1]. This vision was recently supported by the findings of the Fuller Stocktake, which envisages a move towards integrated neighbourhood teams that brings together different primary and community care providers[2]. Since 2019, the Additional Roles Reimbursement Scheme (ARRS) has significantly expanded the number of multidisciplinary roles working in general practice[3]. The scheme includes roles such as mental health practitioners, podiatrists, and dietitians, which would previously have been delivered in community rather than primary care.

Properly resourced, primary care networks (PCNs) could be the foundation for further integration of primary and community care. However, many PCNs do not have adequate support and resourcing to oversee their current responsibilities, let alone set up a significantly more ambitious system. Many PCNs are led by a single clinical director, only funded for part-time work, and have little management structure or capacity. A recent RCGP study found that 34% of general practice staff said their practice did not have enough management expertise to support further shifts towards working at scale.

Recent research by the Kings Fund found that ARRS roles need increased support if they are going to be fully integrated.[4] Further plans to better integrate primary and community care also require GPs to be involved in development and implementation. However, this support is expected to be provided by a GP and community workforce in a state of crisis. Efforts to integrate should include ensuring the necessary capacity and time within the system to enable successful multi-disciplinary teamworking and the provision of care with the patient and their carers at its centre.

Investment in infrastructure and interface are also vital in ensuring effective integration and a single digital record is key for the efficient delivery of primary and community care. Our recent study found that 24% of general practice staff said their practice did not have enough space to house their current multidisciplinary team, let alone additional staff, and 35% said they did not have enough consulting rooms. Upgrades to general practice premises would allow them to serve as community health centres for the delivery of general practice and service a wider range of patients alongside other primary and community care services.

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[1] https://www.rcgp.org.uk/getmedia/ff0f6ea4-bce1-4d4e-befc-d8337db06d0e/RCGP-fit-for-the-future-report-may-2019.pdf

[2] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

[3] https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-additional-roles-reimbursement-scheme-guidance/

[4] https://www.kingsfund.org.uk/publications/integrating-additional-roles-into-primary-care-networks

Challenges facing primary and community care

Workforce and workload

The healthcare system across the country is at breaking point. Services across the board are struggling to recruit and retain the staff needed to support an ageing population with increasingly complex needs. The Health and Social Care Committee's recent inquiry into workforce reported staff shortages for almost every healthcare profession, including general practice, nursing, dentistry, pharmacy, sexual and reproductive healthcare, dietetics, and speech and language therapy. The same inquiry reported worse shortages in social care, during which Care England reported that 95% of care providers were struggling to recruit staff.

These shortages significantly hinder the ability of the system to address the present needs of patients, let alone take further steps towards integration. A lack of workforce drives increasingly higher workloads, which in turn lead to higher staff turnover and a sector struggling to give patients the care that they need. A GP in Leeds said:

> *"My work has changed over the years because of increasing complexity of patient health and social care needs without the resources in the community to meet them and a fragile workforce with high turnover of colleagues in both clinical and non-clinical roles."*

A properly funded workforce plan across primary and community care is essential to enable the system to take steps towards integration. General practice recognises the invaluable care that community teams provide and is keen to move towards the vision of integration as set out in the Fuller Stocktake, but without more resource across the board this will never become a reality. It is only by alleviating workforce pressures that we can begin to give the healthcare workforce more time, enabling them the space to engage in system level decisions making, including how general practice can better integrate with community care.

Infrastructure and interface

In some areas, community and primary care services have been integrated physically by bringing them all under one roof as a community health centre. While these centres have shown promise, the current state of general practice premises and digital infrastructure makes it hard for primary care to deliver the care patients need.

In a recent RCGP study, two in five general practice staff said their premises are not currently fit for purpose. The reasons listed ranged from insufficient consulting rooms, a lack of space for patients and staff and no space for additional GP trainees to reports of leaking roofs and windows repaired with Sellotape. One GP near Exeter told us:

"Our list will have increased by about 3,000 patients in the last 3 years and continues to grow. Whilst there are obviously challenges to recruit [GPs], the biggest challenge is we have no space to offer clinical consultations, and it is appalling that no infrastructure funding was put aside to help us do an extension to the building. The ICB say there is no money although they agree there is a pressing need. We are therefore at breaking point, cannot offer additional consultations safely as we are already at a maximum of trying to work remotely from home calling our patients."

There must be investments in premises to achieve any significant step in the direction of integrated primary and community care. This would enable general practice to house an expanded practice team, allowing practices to serve as centres for the delivery of general practice alongside other primary care services and potentially community care services. These could incorporate wellbeing services, diagnostic services, medical specialty and pop-up clinics, and social prescribing.

The current state of digital infrastructure also limits general practice's ability to integrate with community services. 51% of general practice staff say the ability of their IT systems to exchange information with community teams is not fit for purpose. The recent Health and Social Care Committee expert panel report on the digitalisation of the NHS concluded that the government's progress in digitising the NHS is inadequate. To harness the benefits of digital technology, including better integration between care pathways, investment must be made in digital infrastructure and the creation of a unified shared patient record.

Ways to improve the interface between primary and secondary care to reduce unnecessary workload or duplication should also be considered. The RCGP supports the establishment of effective agreements in every ICS between primary care services and other parts of the system about ways of working. The aim would be to ensure that the patient journey is as smooth and simple as possible and to make sure that workload isn't passed between healthcare settings unnecessarily. Steps to develop local directories of community services should be undertaken so that GPs can easily refer patients to the full range of community care options that are available in their area.

Long-term management of complex conditions

As the population ages, there are increasing numbers of people living with multiple long-term conditions. It is estimated that approximately 26 million people have at least one long-term condition, and 10 million have two or more. These individuals constitute a very significant part of GPs' work, accounting for 50% of all GP appointments in England.[5]

A specific multimorbidity strategy, aligned to the principles of holistic, person-centred care, to shine a light on the issues patients with multiple long-term conditions currently face and issues around receiving linked up, integrated care, is also needed. Commissioning should be developed in a way that reduces the prevalence of the siloed approach to healthcare conditions, promoting a process whereby the money follows the patient rather than commissioning individual conditional services. Healthcare leaders should be encouraged to consider how self-care, self-supported care and social prescribing can be enhanced for people living with multiple long-term conditions.

Barriers to integration and examples of good practice

Examples of successful or innovative models of integration between primary and community care

1. Bromley-by-Bow

At a neighbourhood level, the Bromley-by-Bow Centre in London serves as an example of transformational integrated care. The Centre is a community charity offering over 40 services to the community, including primary care services, employment support, adult social care, activities and social groups, and skill courses. Clinicians work across this integrated system of services to provide holistic treatment that is reflective of patient need and circumstance, including a focus on social prescribing, working with extended teams to address these while maintaining GP continuity.

The Centre was founded as a community space, and through significant investment and attention from local systems was later expanded to include medical services such as general practice. This model runs counter to the approach to delivering integrated care that is currently incentivised, in which PCNs employ additional roles under the ARRS scheme that typically fall under the clinical supervision and responsibility of general practice.

There is no one-size-fits-all approach to delivering integrated care, and the direction taken will depend on the existing structures in place and the needs of the local population. We have already outlined in this submission the considerable workload challenges that make it difficult for general practice to participate and lead on transformational change. Where it is effective, community spaces should be resourced and empowered to work with PCNs to co-design integrated care pathways and spaces that are effective and relevant for their populations. This will require flexibility from local authorities, significant investment, and a commitment to

[5] https://www.england.nhs.uk/wp-content/uploads/2014/09/ltc-infographic.pdf

engagement from ICBs, who should engage with community groups as part of their estate planning processes. It will also require investment in the organisational structures and leadership capabilities of both community groups and PCNs.

2. Merseyside and Cheshire Integrated Health Partnership

Cheshire and Merseyside Integrated Care Board recently developed a set of principles for the development of patient pathways between primary and secondary care.[6] These principles provide a set of guidelines by which service providers can recognise the impact of their actions on other areas of the system and enable them to work more collaboratively with other providers. The principles have been successful in enabling positive working relationships across the system and ensuring patient-centred processes are prioritised.

The principles were developed by the ICB in collaboration with local organisations, including Trusts, primary care, and Local Medical Committees. The relevance of the agreement is due to its reflection of local relationships and priorities, so systems should be encouraged to follow an organic process, which includes all relevant stakeholders, in developing any similar set of principles.

3. North East and North Cumbria

The Great North Care Record is a platform that allows sharing of the health and care information of patients living in North East and North Cumbria as part of the national Shared Care Records programme. The initiative brings together a patient's separate records into a structured, easy-to-read format, giving health and care professionals a more complete view of the care and treatment that patients have received across all services while keeping patient confidentiality.

Prior to the platform, staff from secondary, primary, and community care used separate systems to record patient information, and difficulties sharing this information caused delays in care and treatment. Under the new scheme, a patient's data can be accessed 24/7 by the different professionals who are directly involved in their care. This system has positively impacted patients, reduced the duplication of tests and referrals, and reduced unnecessary workload generation for clinicians and healthcare staff. Efforts to improve integration of care must consider the daily work of healthcare staff and identify where processes can be streamlined and improved, particularly in regards to sharing of patient data and interoperability of IT.

[6] https://www.cheshireandmerseyside.nhs.uk/posts/consensus-on-the-primary-and-secondary-care-interface/

Example of the limits to integration

The Health and Social Care Act 2012 led to the fragmentation of commissioning responsibilities for sexual and reproductive health provision in England between local authorities, CCGs (now ICSs), and NHS England. This has led to a system in which providers are delivering separate services without clearly defined accountabilities, and the linkages between different parts of the care pathway have been lost.

For example, ICSs commission abortion services, while local authorities commission contraceptive care. This creates a break in the care pathway which means that people who access abortion services are not automatically referred into full contraceptive or sexual health services.

A coordinated approach to commissioning of sexual and reproductive health, pooling policy and shared aims, would not only improve patient pathways but would also make the entire system more robust. Efforts to integrate primary and community care services should account for the problems created by different commissioning pathways and seek to clarify respective roles and responsibilities of different services.

ICSs, PCNs and what these mean for patients

Aims and impact of ICSs

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 establishment of ICSs sets the direction for integration that has subsequently been built on by work such as the Fuller Stocktake. 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.

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.

Engagement with the voluntary, community, and social enterprise (VCSE) sector has been built into the structure of ICSs through the establishment of Integrated Care Partnerships (ICPs). However, the development of effective partnerships requires a positive culture of inclusion and collaboration to achieve shared population health outcomes. The size and

diversity of the VCSE sector can create challenges for engagement; it will be important for ICPs to support and enable the structures and relationships that are already forming. Adequate funding and protected time will be required for VCSEs to fully participate in these systems.

Challenges to the establishment of ICSs

There have already been challenges in establishing ICSs that are limiting their ability to deliver on their goals of improved integration.

Lack of a primary care voice: A strong primary care voice at the system level is essential to enable integration of services at the local level. Innovation grows from the ground up, and entrenching space for local leaders in ICS decision-making will build innovation and feasibility into the types of interventions that are designed, and shape the direction of resource allocation towards preventative care. At present, ICBs are made up primarily of representative from secondary care Trusts, with a single spot set aside for primary care; additional seats for primary care leaders are necessary to deliver transformative change.

Time: ICSs are still in an early stage of development and still forming links with the wider healthcare system, but are already being asked to deliver significant pieces of work. Continued reform of the NHS will continue to drive unnecessary bureaucracy and distract systems from the work they must do to deliver on their goals. ICSs must be given the time and headspace to develop the relationships and pathways across the system that will be required to deliver integrated care.

Financial constraints: Many ICSs are carrying historic deficits and operating in financially constrained environments, yet being asked to develop significant new ways of working and provide more investment for prevention mechanisms. The news that ICSs are having their staffing budget cut by 30% is likely to have disastrous consequences for any attempts to integrate primary and community care. This approach is unlikely to be successful, and additional resource is needed for them to properly establish links across the system and develop services that will be effective.

Insufficient support: No other sector would expect to achieve the degree of change required of the health and care sector without investment in change management support. The lack of a systematic and planned transition towards new ways of working is likely to amplify costs and productivity inefficiencies. PCNs, in particular, need sufficient investment in leadership and management capacity to deliver the changes in service delivery that are expected of them. Most PCN clinical directors are not resourced to work full-time; if there is a serious commitment to integrated care, additional management capacity is urgently needed.

Low trust: A high-trust environment, in which systems are allowed to fail, is required to encourage innovation in delivery of services. For ICSs and service providers to be able to deliver care differently, different priorities in standard-setting and accountability are required. Regulation must be flexible to account for new initiatives, interventions, and ways of working to be established and recognise the trajectory of travel rather than penalising systems for still being on the journey.

Primary Care Networks

PCNs are still relatively new, are not legal entities in their own right, and there are many varied perspectives on what PCNs are for and what they can achieve. Even before the challenges of COVID-19, the 2019 consultation on the service specifications revealed serious concerns about unrealistic expectations for PCNs. General practice has been asked to invest in new workforce roles with little help to embed and supervise team members new to primary care.

Despite this, PCNs have delivered substantial amounts of work since their instatement. The most notable example was the COVID-19 vaccination programme, in which GP practices, clusters and PCNs worked rapidly to develop entirely new service delivery models that have, to date, provided 151,248,820 vaccinations across the UK. The approach taken to this programme - in which local systems were fully enabled to develop solutions that met the needs of their populations - is the most effective way to allow PCNs to facilitate joined-up working.

PCNs will require continued support to develop to a place where they can fulfil the expectations of the laid out in various NHS strategies. New organisations take time to reach a shared vision and build a team that can work towards delivering it. However, there is considerable concern that it has been challenging to properly embed in primary care the staff employed as part of the Additional Roles Reimbursement Scheme (ARRS). The additional supervision required by clinicians further reduces the amount of time they can spend with patients, and there have been challenges for some ARRS staff in feeling adequately supported by PCNs of varying maturity. Additional support is required to ensure these staff are enabled to provide different services for patients, rather than relying on an already-stretched general practice workforce to deliver these.

The Fuller Stocktake recommends that GPs are given protected time to build relationships locally but many practices report not having the ability, support or links to feed into decisions made at the system level. For many clinicians there is simply no time to sit down and develop localised practice-level plans for further integration with community care. Protected

time for relationship building would be a vital step to improve integration of services.

Patient access and satisfaction
The NHS is in crisis. There are simply not enough staff to meet patient demand and to deliver the care that patients need. The CQC in their 2022 State of Care report referred to a system in "gridlock" – there are not enough resources to meet the needs of a growing population with increasingly complex needs.

No amount of restructuring of the NHS will address this problem. Significant investment is needed now to address workforce shortages and enable patients to receive the care they deserve.

The primary care model
As mentioned, primary care has delivered significant amounts of work in recent years through the development of more integrated primary care in PCNs. The further visions towards integration, such as the Fuller Stocktake or the Hewitt Review, provide ideas of how the primary care model can continue to adapt to the changing needs of patients and recognise the importance of nurturing leadership to achieve this.

The foundations for the integrated neighbourhood teams laid out in the Fuller Stocktake are already being built as community teams begin to form around PCN boundaries. However, the core component missing from the current and anticipated primary care model is a stable, mature, and resourced leadership and management structure. The provision of organisational development and change management would have, in the past, fallen to CCGs. ICSs must focus heavily on providing organisational development and change management resource for PCNs and primary care providers to ensure mature leadership at place.

Primary care and outside hospital care
General practice can and does play an important role in preventing unnecessary hospital admissions by supporting patients to manage their care in the community. GPs already make up a major part of the out of hospital NHS workforce and their generalist skills are essential to the treatment of patients in these settings.

GPs are ideally placed to contribute to the development, commissioning, and delivery of out of hospital care that meet the needs of local patients. However, the capacity of GPs to meet the level and type of demand from patients is stretched. There are not enough GPs to deliver the necessary level of care.

Primary care and out of hours services

General practice has a vital role to play in the delivery of high-quality patient care at all times of the day, including outside normal working hours and in the face of urgent patient needs. Patients seeking help from the NHS during out of hours periods are often at their most vulnerable, and for many of these patients general practice is best placed to provide the care they need. The RCGP believes that a stronger focus is required on the role of the GP in providing out of hours care, working in partnership with other services in the community. Primary care must collectively develop the provision of modern 24/7 care services for patients with urgent needs.

The RCGP believes timely and equitable access, adequate and balanced resourcing, integration, quality, safety, and innovation are some of the key principles which should underpin a sustainable future model of out of hours care. The current out of hours training and supervision arrangements, systems, infrastructure, communications, and incentives must be urgently reviewed and adjusted in line with these principles to effectively support, retain and attract out of hours GPs.

Mental health services, social care, palliative care, prison cover, community health cover and other care services within the community should be readily available to support GPs in out of hours periods. The development of urgent and out of hours service arrangements must reflect the increasing number of practices moving towards 'at scale' working and collaborative network models. Considerations should include clarity of accountabilities, quality incentives, and the involvement of out of hours providers in the local health economy to ensure they are able to develop integrated care pathways with other parts of the system including A&E or ED and ambulance services.

Primary care and mental health provision and parity

Challenges around parity for mental health provision are complex. GPs regularly provide care for common mental health problems, and many are reporting seeing rising numbers of patients seeking support for mental health. With urgent referrals to IAPT services sometimes taking months to come through, general practice is increasingly becoming the urgent care backstop for mental health. Significant numbers of people are also assessed as too complex for IAPT services and referred on to specialist mental health services, however many of these referrals are rejected, again leaving GPs to pick up the pieces.

The new GP contract for 2022/23 allows for up to two mental health practitioners per PCN via the Additional Roles Reimbursement Scheme

and this will increase to three in 23/24. However according to a recent RCGP survey only 44% of GPs say they have access to mental health practitioners at their practice, with 24% of these respondents rating access as either not very good or not good at all. It is vital these additional roles are accessible and that general practice has the space to accommodate these additional staff, in our survey 74% of respondents said that "My practice does not have sufficient physical space necessary to accommodate new multidisciplinary team staff" (RCGP Tracking Survey 2022).

There is also a desperate need for better funding for both IAPT and specialist mental health services so that waitlists are reduced and people who desperately need support can move out of primary care into the specialist care they need. RCGP believes there needs to be a review of the commissioning pathways for mental health alongside other health services to ensure they are joined up between primary, community, and secondary care, as well as with public health and social care. Further investment is also needed in social prescribers and community link workers, as well as investment in clinical 'leads' across networks of practices to lead the work required to build community links between services and with general practice.

Health inequalities and primary care

Deep End Project - Scotland

In 2009, the Deep End project[7] started operating, comprising general practices serving the 100 most deprived populations in Scotland. Since then, the project has expanded, including new members and initiatives in England, Ireland, Australia, and recently in Wales.

After the first eight years, the Deep End project has developed a number of collaborative projects including the Link Worker Programme (rolled out via 250 new community link worker posts), embedded specialist addiction nurses and financial advisors into participating practices, and helped to increase clinical capacity for some Deep End practices via GP fellows and locums.

The Link Workers Programme, funded by the Scottish Government, has been one of the four key features of the project. Link workers have been forging links with community resources and signposting patients to access relevant resources. Link workers have enabled practices to better respond

[7] https://www.gla.ac.uk/media/Media_557259_smxx.pdf

to patients' problems, link them with relevant community resources, address fragmented care, and build knowledge and confidence in patients.

Social prescribing – Slough, England

85% of Frimley Integrated Care Board's deprived population lives in Slough, which prompted the Slough Place team to lead the design of improved service delivery between general practice and community services.[8] In this initiative, social prescribing link workers in the primary care network spearheaded implementation and created alliances within the community, including with housing support, the citizens advice bureau, food banks, mental health services and drug and alcohol support. Link workers also developed a strong network with community development workers from the local authority, faith leaders, and the voluntary sector.

The initiative identified residents in the most deprived areas living with multiple chronic conditions (using the Core20PLUS5 approach[9]) to enable link workers to lead interventions for these populations. The programme has driven an increase in the number of completed health checks among the diabetic and hypertensive population, as well as a reduction in A&E presentations, NHS 111 and emergency calls, and inpatient admissions.

Health inequalities: A varying picture

Inequalities in health exist across the country, however, their distribution is unequal. Data shows that people living in areas of greatest deprivation in England are diagnosed with serious illnesses earlier and die sooner than their peers in more affluent areas. Women living in the poorest areas have a life expectancy of five years shorter than those in the wealthiest areas, while men from poor areas will be expected to die nine years earlier. Almost 10 million people live in rural areas in England, and they experience poorer access to health and social care than populations in urban areas. Rurality for the population has translated into the disproportionate presence of older residents and a higher number of comorbidities[10].

GP practices in the most deprived areas had 2,400 patients per fully-qualified doctor, while those in the least deprived areas had 2,100 patients, by October of 2022[11]. Research from the Health Foundation in

[8] https://www.england.nhs.uk/blog/addressing-health-inequalities-in-slough-through-social-prescribing/

[9] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

[10] https://rsnonline.org.uk/images/publications/RuralHealthandCareAPPGInquiryRep.pdf

[11] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/trendsinpatienttostaffnumbersatgppracticesinengland/2022#:~:text=GP%20practices%20in%20the%20most,number%20of%20patients%20per%20nurse.

2021 showed that GPs in deprived parts of England were earning 7% less per patient than GPs in affluent areas[12]. Practices in areas of higher deprivation receive less funding than those in less deprived areas, as the Carr-Hill formula, which distributes the resources in England, does not account for deprivation.

In all, this results in practices in deprived areas with the same or fewer resources to provide care to a larger number of people with more complex morbidities, which exacerbates the disadvantages faced by this vulnerable population and the difficulties of the care professionals working in these areas.

Health technologies

A recent RCGP survey found that 46% of general practice staff say their practice does not use online triage tools, almost 45% of these because of concerns about patient and carer access to technology. Similarly, 32% said inequalities in patient and carer access to technology are a reason their practice does not use video consultations. These concerns are supported by data from 2022 which reveals 11 million people in the UK lack basic digital skills or do not use digital technology at all[13].

This data points to inequalities in access to digital technology as a barrier to improving the use of these technologies in healthcare. There is need for a more inclusive design of NHS digital systems, with measures such as language, accessibility, affordability, and simplicity prioritised; improvements to digital infrastructure across the country, to ensure that practices and patients have access to the technology they need; and work to improve digital literacy for patients.

Barriers to data and information sharing

The 2022 RCGP survey revealed that 65% of general practice staff report having IT systems not fit for purpose or of an acceptable standard to exchange information with secondary care. Similar issues might be limiting information sharing with community care.

For interoperability to be a reality the focus should go beyond 'digitising' data to making it accessible and editable by those involved in patient care. For example, many Trusts have been 'digitising' case files by scanning them into PDF format; these uncategorised, unsearchable documents are largely inaccessible to most clinicians, who simply do not have the time to find and then review them for important information under current workforce pressures.

[12] https://www.health.org.uk/news-and-comment/consultation-responses/the-future-of-general-practice

[13] https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/digital-inclusion

It will be critical that this progress in access and editing rights is accompanied by fully attributable user profiles, to allow visibility of where entries have been made. Consideration will also need to be given to proper staff training to ensure technically interoperable systems are used in ways that make data functionally usable in different settings.

COVID-19 technology learnings
During the pandemic, general practice responded to government guidance by rapidly increasing the use of remote consultations. After the peak of the pandemic, general practice has been returning to delivering more consultations face-to-face. However, it is important we don't lose the benefits of remote consultations for patients who want or need them.

The NHS currently publishes data on what proportion of appointments are carried out remotely. This data has been used by newspapers to "name and shame" practices with higher proportion of remote consultations, without taking account of the different needs of their patients. Further moves in this direction could lead to practices prioritising face to face appointments when it goes against patient wishes or clinical need.

Implications of the Government's long-term workforce plan
While the plan has not been published at the time of writing, it will have serious implications for the entirety of the healthcare workforce, with projections of the healthcare workforce required over the next 15 years. Depending on what is presented in the plan and the figures attached to various workforce groups, certain professions could be given priority or be forgotten about by the government.

In terms of primary care, we know that GPs will be picked out as a specific profession. We hope that the projections will be accurate and based on demand, but also realistic of the pressures that GPs are facing. For example, in order to increase the GP workforce, retention is key as otherwise increasing numbers of GPs will continue to leave prematurely and we will never be able to plug the gap.

The wider multidisciplinary team and allied health professionals are also integral to the work of general practice and primary care. These roles have already expanded drastically in recent years due to the introduction of ARRS, and the workforce plan will signal whether the government plans to continue to expand these roles. It is important that these roles are considered in conjunction with GPs. For example, continuing to increase these roles will place greater supervisory pressure on GPs and MDT roles cannot be considered as "replacements" for the greater number of GPs required.

Key recommendation

The most significant challenge to improved integration of primary and community care is the lack of clear strategic oversight and planning. PCNs and ICSs are already delivering significant changes in how primary and community care work together, but the management structures underpinning this new way of working have not been fully developed and are insufficient to deliver a planned and systematic transition to new ways of working. Systems need to invest in primary care leadership across the board, both by incorporating a stronger primary care voice into ICBs and by nurturing and resourcing PCN leadership and management. Of course, none of this will be effective without addressing the fundamental workforce and workload challenges affecting the sector and urgent Government action is needed to combat these.

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