

## Written evidence submitted by The Royal College of General Practitioners (HSC0950)

March 2021

- The Royal College of General Practitioners (RCGP) welcomes the opportunity to respond to the Health and Social Care Select Committee Inquiry into the Department's white paper, *Integration and Innovation: working together to improve health and social care for all.*<sup>i</sup>
- The RCGP is the largest membership organisation in the UK solely for GPs. Founded in 1952, it has 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.
- We have previously responded to the Health and Social Care Select Committee inquiry on legislative changes to for the NHS Long Term Plan, and the NHS England and Improvement (NHSE/I) engagement on the next steps for integrated care. Details to access our responses can be found in the footnotes.<sup>ii,iii</sup>

### Executive Summary

1. We are broadly supportive of the aims of the white paper. The RCGP has long called for better integration of care across health systems, for the NHS to work with local government and other stakeholders to improve care for patients, to reduce unnecessary bureaucratic workload during the commissioning of services, and draw together the arm's length bodies to provide a clear line of accountability.
2. However, it is important to note that the success of the integration agenda does not lie in the changes to legislation or the modifications to decision making powers within central authorities. Successful integration relies on the building blocks of newly designed patient pathways and the relationships between frontline health professionals, their teams and patients they serve.
3. The proposals in this white paper will not be successful unless more is done to focus on facilitating collaboration between clinicians and patients. This work cannot be legislated for and will require clear implementation guidance and planning for Integrated Care Systems (ICS) to ensure their focus is on creating an environment that facilitates this work at the level of patient care.
4. There is strong evidence from across the world that empowered and well-resourced primary care is required to create a successful integrated care system. The majority of NHS patient contact takes place in general practice with most interactions being resolved within primary care, without being referred into secondary services. In addition to a legal duty to collaborate, we would like to see legislation include system accountability for reducing health inequalities, and a more detailed outline of the workforce planning responsibilities placed on the Secretary of State. By outlining these duties, this legislation will establish a long term strategic focus on these enduring challenges.
5. The proposals in the white paper do not sufficiently account for the system needs of primary care. In many parts of the country, general practice is smaller in scale, less mature in organisational terms than foundation trusts, and is often less influential within the wider system. Primary Care Networks (PCNs) have had little time to develop the leadership capacity and organisational maturity that would enable them to fulfil the role envisioned for them in this white paper. Additional resource is essential to develop this much needed capacity in primary care. We are concerned that guidance for providers and

collaboration has been principally focused on those more established and larger organisations. In the absence of careful planning, direction and incentives, integrated care systems and provider collaboratives risk being dominated by these larger providers. This will not empower primary care to facilitate true integration through pathway redesign and will ultimately hinder the success of the reforms.

## **A. Integrated Care Systems**

### *Primary care as a driver of successful integration*

6. The most important aim for any NHS reform should be to improve care for patients. The RCGP is pleased to see acknowledgement in the w of the limits of legislation in effecting meaningful change and reform in the health service. As the nation's most treasured public service, the NHS has been undergone significant structural reforms in the past that have failed to achieve their stated aims. The hard work of delivering and improving care must be entrusted to the professionals working in the health service, with support from central institutions.
7. Government must have realistic expectations and communicate clear messages about the time needed to develop the relationships and collaborative culture required. The implementation of the legislative changes will need strong engagement from clinicians and the populations they serve in shaping

strategies and services at system and place level. This may prove challenging as the health service recovers from the effects of the pandemic, begins to manage the backlog of care that has built up, and 'initiative fatigue' experienced by front line staff who may have experienced many local and national service restructures.<sup>iv</sup>

8. Collaboration is a positive principle to guide the integration of care at system and place level. The RCGP recognises that service providers work better together around a common goal than competing against one another. However, as with all policy that aims to create an environment where progress comes from the bottom up, there will be variation in successful implementation.<sup>v</sup> The permissive nature of the proposals will naturally lead to different levels of collaboration across systems, which will rely on the relationships between key players at the system level. This will be particularly challenging in systems that have been under severe financial strain, where the organisational culture within an ICS is not yet well established, or where the interests and accountabilities of large and powerful organisations may overtake the aims of the wider system.<sup>vi</sup> This will hamper efforts to truly transform care and may result in more of the status quo. Appropriate guidance and effective oversight will be crucial to upholding the collaboration duty, and ensuring power and resource are shared and devolved fairly.

#### *GP leadership within the system*

9. The majority of patient interaction takes place in general practice, with most health problems being resolved within primary care.<sup>vii</sup> The NHS Long Term Plan outlines the overarching aim of moving more care away from secondary care, into community and primary care settings.<sup>viii</sup> There is considerable evidence that a strong primary care service is a key determinant of an effective and efficient health service.<sup>ix</sup> Consequently, securing engagement and organisational buy in from GPs at all levels of a system must be a key consideration of any integrated care system.
10. PCNs are a foundational building block to the implementation of the NHS Long Term Plan. These groups of practices will be responsible for much of the population health management, and enhanced primary and community services used by patients. Unfortunately, these networks remain substantially under resourced while they are expected to deliver against nationally decided service specifications that leave little space for them to develop and connect with their local aims.<sup>x</sup> A significant amount of additional investment and development is needed for PCNs, and the clinicians that will lead the work they are responsible for, to deliver on the integrated care agenda. Cultivating collaborative cultures and leadership capacity within primary care networks must be a core goal for any integrated care system. In the meantime, implementation plans will need to include specific guidance to ensure existing GP leaders are at the heart of system decision making.
11. As independent contractors, often operating as small or medium sized businesses, GPs do not have protected and resourced time within their contract in the same way as clinicians contracted to NHS Trusts. This means that GPs often face structural and professional barriers to fully developing their leadership potential within the wider system.<sup>xi</sup> The structures necessary to develop GP leaders and leadership capacity must be considered separately from those employed by secondary care trusts if there is to be engagement from clinicians across the board. Without this, there is a significant risk that opportunities for GPs to participate with broader strategic projects, both locally and at the system level, will be a secondary consideration as a result of the different business models in primary care. For ICSs to secure meaningful GP engagement, they will need to ensure learning and development routes, and ringfenced resources, are available for GPs to be able to take part in committees at all levels of place and system from the very beginning.

12. The knowledge and skills of GPs in planning and delivering quality care for their patients was a foundational principle in the creation of commissioning groups.<sup>xii</sup> These organisations have successfully developed GPs to have a system wide view of services, build relationships with other providers in their localities, and have been accountable to the patient populations that they serve. Clinical Commissioning Groups (CCGs) are also an established route for the professional development of GPs who want to shape care beyond their practice, at a system level. ICSs must embed strong GP leadership voices and career routes in their governance structures and broader system workforce plans.

#### *Patient representation*

13. The primary concern for all health and care is, and should be, the needs of the patient. The white paper is clear that principles of patient choice will be strengthened as part of the legislation. However, the real impact of these changes will be seen by those receiving care. The RCGP would like to see a stronger commitment within the legislation, and the corresponding implementation plans, to better embed the voice and influence of patients throughout the integrated care system from the beginning of any service development and change. From patient and carer participation groups at the practice level, through neighbourhood engagement exercises, to system wide consultations, more needs to be done to ensure a golden thread of patient representation links the local level to those responsible for planning care at the top. This will require a well-defined and resourced infrastructure and strategy that is tailored to the different patient groups within the system.

#### *Health inequalities*

14. General practice is an anchor institution for all its patients, accessible to everyone and based in the communities it serves. Before the pandemic, many GPs were already looking for ways to work with their more socially vulnerable patients to improve their health in the long term. COVID-19 has highlighted why this work is important, and how it will be vital during the recovery phase.<sup>xiii</sup> There is also increasing evidence that the current models of health service funding are resulting in the unintended consequence of worsening health inequalities.<sup>xiv</sup> The implementation of the white paper proposals and ICSs must carefully consider how general practice can be better harnessed to address ingrained health inequalities and ensure better health outcomes for those who need it most.
15. Addressing inequalities in health outcomes has been a central tenet of the NHS since its creation in 1945. As the health service moves away from the first year of the pandemic and into a recovery phase, ensuring equity of access to health services and focusing care where it is most needed will be a necessary focus for all ICSs. The white paper emphasises the need to tackle the growing health inequalities, and many aspects of the reforms aim to tackle this issue. However, the legislative proposals do not go far enough. There needs to be stronger accountability within legislation for health systems to truly work together and in a meaningful way to tackle the wider determinants of health, and address inequity in health outcomes. While the health system can only play one part in this wide-scale crisis, it is essential to enable and authorise activity through healthcare settings which can contribute to these aims, and this will only happen in a cross-NHS way if there is clear lines of responsibility. The RCGP would like to see a statutory mechanism that will ensure ICSs have legal accountability for working to address unnecessary inequality in health outcomes that are experienced by so many.

## B. Workforce and the Quadruple Aim

16. The NHS workforce, across all parts of the system, will be the most important element to implementing the ambitions laid out in this white paper. Workforce shortages will be a substantial barrier to progress on the NHS Long Term Plan objectives. In 2020, 71% of surveyed GPs based in England said that they had found it difficult to recruit a GP.<sup>xv</sup> It is encouraging that the Department of Health and Social Care (DHSC) recognises that the hard work of implementing the overarching aims of integrating care will fall to those delivering patient care. However, more needs to be done to grow the workforce in the long term, and to improve GP retention rates.
17. The RCGP Workforce Roadmap, published in January 2020, outlined actions policy makers must take to cultivate the primary care workforce in the medium and long term, and many of these are yet to be delivered.<sup>xvi</sup> We need long-term focused investment in the general practice workforce, including additional funding to train the future workforce, wide-reaching action to retain staff and ensure long, fulfilling careers. In addition, continued efforts to expand and integrate multidisciplinary teams will be essential to manage increasing workload pressures within primary care. Crucially, all of which needs to be underpinned by comprehensive and transparent workforce planning that seeks to deliver sustainable change.<sup>xvii</sup>
18. It is essential that workforce challenges are given more weight within this legislative change, and the wider implementation plans. The duty on the Secretary of State for Health and Social Care to report to parliament every five years is a welcome first step providing an important opportunity for parliamentary scrutiny, but this change alone will not give adequate impetus to the most important enabler for the NHS plans.
19. The duty on the Secretary of State for Health and Social Care should also be strengthened to specify a range of time horizons on which they should report on the planning for the NHS workforce. This should be at five, ten, and 25-year horizons. Furthermore, the report from the Secretary of State must specify where responsibilities for workforce planning sit in NHS structures and mandate the publication of relevant information on a more regular basis to inform planning discussions. Additional guidance to sit alongside the NHS Bill should clarify how these national obligations relate to local planning activity. Although there are no quick fixes to the workforce shortages facing general practice and other areas of healthcare, these changes will allow for better informed and more transparent planning.
20. The RCGP agrees that a shared duty towards the ‘triple aim’ of better health for everyone, better care for all patients, and efficient use of NHS resources is a step in the right direction. However, we believe this does not go far enough in outlining principles for NHS organisations. Along with patients, the clinical workforce must be a central factor in any NHS reform, particularly given the risk of an exodus of experienced staff as COVID19 recedes. Engaged, productive and contented staff are an essential part of an effective healthcare system, and there is strong evidence that the wellbeing of clinicians is linked to staff retention rates, and the quality of care.<sup>xviii</sup> Including this additional aim at the heart of NHS legislation would send a strong message to the hard working professionals that their wellbeing is taken seriously and their contributions are valued. It would be a legislative commitment that would maintain accountability on this fundamental area for the health service.

### **C. Joint Committees, Commissioning and Appointments**

21. The RCGP is broadly supportive of the proposals to grant ICSs the power to establish joint committees, provide mechanisms to support more collaborative commissioning, and enable joint appointments across different organisations. The aims of these proposals are in keeping with the wider principles of the integrated care agenda. However, the success of these proposals will rest upon how system leaders and their teams choose to implement them. It is vital that those taking decisions that affect the wider system are truly able to consider all parts of the system, and that will require consideration of how to ensure the right people are represented at all levels.

### **D. Bureaucracy**

22. During its passage through Parliament, the RCGP repeatedly opposed the provisions in Clause 75 of the Health and Social Care Act 2012 and called for Monitor's role to be focused on encouraging collaboration and integration. The RCGP therefore strongly welcomes the intention to revoke the Section 75 powers of the Act, which we believe have acted as a significant barrier to the development of new care models and collaboration between NHS providers over the last decade.
23. The RCGP would like to see further detail on the proposals include provision for the creation of new trusts for the purposes of providing integrated care and what this would mean in practice. The creation of integrated care trusts would have implications for those holding GMS contracts, and others signed up to the Primary Care Network Directed Enhanced Services. The RCGP regards contract negotiations and evaluations to be the preserve of the British Medical Association (BMA); however, since these changes could have a significant impact on general practice more broadly, the RCGP would like to see a strong, clear commitment from government that creation of these trusts would require buy-in from local general practice providers.
24. The RCGP responded to the 2018 NHS England consultation on the Integrated Care Provider contract, which can be found on our website.<sup>xix</sup>

### **E. Data**

25. The RCGP is supportive of the importance of data sharing and interoperability to support patient care and healthcare planning, including to enable research which benefits the NHS and patients first and foremost. We agree that standardisation of data collection and storage is a critical element of this, as well as the opportunity to meaningfully analyse datasets. However, any overarching powers to require the sharing of data, even where anonymised, will also require significant public trust as well as trust from the NHS workforce. Clear public messaging will be required that outlines what data will be used and how it can improve care for patients. New rules must take care to adequately recognise the risks relating to data breaches, and possible reidentification by inference, whereby records can be traced to an individual by virtue of publicly available knowledge of characteristics and life events.
26. It will also be important to consider how the skills and knowledge to interrogate data can be better embedded throughout all levels of the NHS. ICSs must be supported to access good locally relevant datasets at neighbourhood level, as well as to access the analytical skills and tools to use it to plan and deliver care to those who need it. This work must be driven by quality rather than performance

management. Good data and understanding will help the creation, monitoring and evaluation of services that focus on outcomes from the bottom up, ultimately driving improvement across the sector.

27. The implementation plan for this element of the Bill must consider how the data can provide actionable insights at place and neighbourhood level. In our *Digital Technology Roadmap*, published in 2019, the College called for more data analysts to be deployed in primary care, to produce digestible information for clinicians and their teams.<sup>xx</sup> Learning and development opportunities in data analysis must also be expanded to nurture the skills of existing NHS staff. This will enable them to collaborate more closely with data analysts, ensure insights meets the needs of their patient populations, as well as identify new opportunities for services at the local level. This will be a crucial aspect of supporting PCNs implement effective tools for population health approaches at their local level, but is an area where capacity is currently lacking. Targeted recruitment and development of analytical capability within PCNs will enable them to better understand the needs of the populations they serve, to plan and deliver quality care, and will help to drive a culture of quality improvement that is cultivated from the bottom up.

#### **F. Mandate**

28. The RCGP recognises that the process of delivering a mandate for the NHS should be done in a manner that is timely, meaningfully related to processes relating to NHS planning processes and lower in bureaucratic obligations that add little value. However, while decoupling the NHS mandate and NHS capital and revenue resources may be sensible from an administrative perspective, it is important that the strategic aims and funding to support it remain closely aligned.

#### **G. Reconfiguration and Secretary of State Powers**

29. The RCGP has significant concerns in relation to the proposals to make it easier for a Secretary of State for Health and Social Care to intervene in local service reconfigurations. While it is important that decisions about service changes are made in a timely fashion, these are judgements are often challenging. The slow-moving process is a necessary by-product of taking the time to engage with local populations and NHS staff and come to the correct decision. It is possible to imagine these top-down powers being triggered in response to political pressures unrelated to the overarching needs of patients, the greater good for local health and care services, or contrary professional advice. This must be a consideration of any legislative changes.
30. The use of these consolidated executive powers is, of course, not anticipated to be a frequent event. However, the situations where such challenges arise will certainly be very impactful to local health economies, service provision, and the professional and patient relationships that will be a vital part of making changes successful. More detail is required on how independent advice will be sought and considered, and stronger safeguards are needed to make certain that interventions in reconfigurations are for the greater good for patients and the service.

#### **H. Additional aspects to consider**

31. The RCGP, alongside the BMA and General Medical Council (GMC), have made a joint statement calling for the formal recognition of GPs as specialists in general practice/family medicine in the UK.<sup>xxi</sup> This change in the Medical Act is long overdue, in the spirit of breaking down perceived barriers between primary and secondary care. At a time of major system change, it is important that GPs and secondary

care consultants are perceived as peers and experts in their relevant fields. The necessary changes to enable this have also been supported by the independent review of the partnership model completed in 2018.<sup>xxii</sup>

32. It is an anomaly that the postgraduate GP Speciality Training (GPST) remains formally unrecognised in this respect, and we continue to call upon the government and GMC to make the changes necessary to add GPs to the List of Specialists, and subsequently for the status of GPs to be formally equal to that of their secondary care colleagues. As we move to a more integrated system it is essential that barriers between primary and hospital care are broken down, that GPs are given a strong voice in the system. Formally recognised as specialists in general medicine will go some way to demonstrating the underlying principles that integrated care is based upon.
33. The RCGP is supportive of the medical examiner system put on statutory footing across all parts of the health service. We would like to see more detail on the governance structures for medical examiners including how the relevant GPs, as expert medical generalists, will be fully engaged in shaping the system that is implemented for primary care. It is vital that the system is resourced to comprehensively evaluate deaths within the service they occurred. This will require a clear plan to train and recruit more GPs into medical examiner posts, proportionate to the activity that takes place there.

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