# Response ID ANON-9K5H-JWJ1-W

Submitted to **Your views: building a strong, integrated care system across England**
Submitted on **2020-12-21 15:32:39**

## Integrated Care System (ICS) legislation

### 1 What is your name?

**Name:**
Samantha Dowling

### 2 In what capacity are you responding?

**In what capacity are you responding?:**
Independent provider organisation

**If you have selected 'Other', please specify::**

### 3 Are you responding on behalf of an organisation?

Yes

**Organisation name::**
Londonwide LMCs

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### 4 Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Strongly disagree

**If you have any specific comments or additional information to provide, please provide it in the text box below::**
The proposals outlined in the document are amongst the most significant potential NHS changes in recent years. As such, it is notable that whilst the document (not consultation) seeks views, it is explicitly not seeking deep qualitative input. We are also advised that when presented to colleagues in London these proposals were referenced as “not a consultation, but rather an engagement process (ie the outcome is unlikely to change)”. As such, it is difficult to agree that the document and its contents set the scene for the right foundation for the NHS for the next decade. One GP representative commented on the proposals: “They’ve already decided what they are going to do and this is just a sop to some sort of engagement.” continuing “They don’t care that we deal with 90% of NHS contacts and that our gatekeeper model saves the NHS billions of pounds compared with other countries where people have direct access to secondary care.”

The document’s proposals lean heavily towards option 2, suggesting the measures therein improve clarity and simplify bureaucracy. However there are concerns that option 2 increases centralisation and, alongside governance changes including a removal of mandatory general practice provider membership of the proposed newly legally configured structures (cf question 6), weakens scrutiny.

The introduction mentions bottom-up reform and local decisions around people’s health but there has not, to date, been any meaningful consultation on ICS footprints, authority or governance at either a national or regional level. These reforms potentially increase the power of acute trusts and large-scale secondary providers by diminishing commissioning power and undermining, or removing, the autonomy of primary care and community providers by placing them within a larger and more bureaucratic structure without seeking to provide equitable representation by volume of patient engagements, number of sites, or any other metric. Particularly notable is the absence of mandatory general practice provider representation from ICS governance arrangements shared to date. Again, without meaningful consultation in both the form in which the proposals have been shared, and the timing (an abbreviated consultation period, conducted over the Christmas and New Year, mid pandemic).

Londonwide LMCs does not believe that the dilution of general practice provider representation or the amalgamation of practices and Primary Care Networks into trusts is in the interest of patients or consistent with the provision of quality general practice care in the community, close to the point of need. Whilst it is clear that the relationship between the different strata of the health system needs attention, and that the newly created PCNs need to be involved, the omission of Local Medical Committees – the representative and collaborative bodies supporting the provision of effective and sustainable general practice care across England the organisations with statutory authority to represent general practice – is one which must be addressed. Provider voice in primary care leadership is essential and the inevitable demands of being both a practitioner and a policy maker within the independent contractor-led model of general practice means that these individual representatives are reliant on the support provided by a robust and collaborative LMC.

Throughout the document there is a lack of clarity about the mechanism and responsibility for primary care voice and concerns to be considered. Outwith the activities of current LMC networks, there are few occasions where the interests of practices can be raised in a consolidated, considered way. It is therefore concerning that whilst there are several opaque references to primary care leaders and primary care leaders (2.17 “a leading role for clinical primary care leaders through primary care networks”; 2.24 clinical and professional leadership; 2.25 “place-based partnership”; 2.31 Primary care provider leadership) these leadership roles and positions are undefined, not explicitly associated with provider voice, and not identified as activities expected of the statutory local representative committee representatives.

Concerns expressed by London practices regarding the new entities, and the mandatory governance role for local government contrasted with the omission of local general practice provider representation in the form of LMCs, include “we will find that all such flexibility is lost as the accountants and financial staff in the LA will be scrutinising every proposal, all in the context of what the local political, not clinical, need will be.” and that “…Acutes will get away with whatever they want … but General Practice will be targeted.”

Considering the original five principles outlined by the BMA when ICSs were first created in their current, non-statutory form (endorsed by Londonwide LMCs and other GP organisations), one of which was that they must “protect the partnership model of general practice and GPs’ independent contractor status”. The five tests are here: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/integration/integrated-care-systems-icss. Whilst the proposals set out by NHSE/I do not explicitly contain any measures that will directly alter the partnership model or the independent contractor status of GPs. However, the proposals raise questions about future direction of travel. We believe that any future organisational model must:

• ensure the pay and conditions of all NHS staff are fully protected
• protect the partnership model of general practice and GPs’ independent contractor status
• only be pursued with demonstrable engagement with frontline clinicians and the public, and must allow local stakeholders to challenge plans
• be given proper funding and time to develop, with patient care and the integration of services prioritised ahead of financial imperatives and savings
• be operated by NHS and publicly accountable bodies, free from competition and privatisation.

Fears have been expressed about the loss of general practice as a result of these measures and the underlying proposition of change to the GP contract, despite the incredible skill, adaptability and resilience shown by general practice teams during this pandemic. Furthermore, loss of local leadership and expertise with the centralisation of decision making and funding and propose a more respectful inclusion of primary care representation to account for the large amount of care that is overseen and dealt with in primary care.

The funding models and comments regarding financial favouring episodic care also underline the lack of understanding of what general practice provides for the patient population it serves. Whilst much care may be recorded episodically and delivered at the time of need, this generally takes place in the context of long-standing relationships with the patients and their community. Episodic care does not automatically equate to activity-based payment or recognise and value the vital patient doctor relationship.

We recognised that each ICP is unique and the partnerships are at different stages and believe that there is a strong case to take a more measured approach to creating any new statutory bodies, rather than progressing such significant measures in a climate of significant challenges, not least Covid-19 and the roll out of the largest mass vaccination programme in decades, which will last throughout the intervening period from now to 2022. System priorities should be driven by locally generated understanding of how we plan and deliver together and impact key outcomes. We need to work together to help shape this, and to reflect on what has worked well and what lessons can be shared from the STP/ICP/ICS journey so far – using this to understand what has contributed to effective partnership working to date.

### 5 Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

Strongly disagree

**If you have any specific comments or additional information to provide, please provide it in the text box below::**
Londonwide LMCs has sought views on the proposals outlined in the document. Many practitioners have expressed concern that the inevitable outcome of option 2 is “practices or PCNs being absorbed into trusts”. Whilst the newly created PCNs clearly need to be involved, the omission of the representative and collaborative bodies supporting the provision of effective and sustainable general practice care across England, Local Medical Committees, is apparent. Provider voice in primary care leadership is essential and the inevitable demands of being both a practitioner and a policy maker within the independent contractor-led model of general practice means that these individual representatives are reliant on the support provided by a robust and collaborative LMC.

Section 2.5 on provider collaborations specifically mentions vertical integration without further exploring or identifying how representatives of individual fledgling PCNs might influence a collaborative which contains (if it is not being led by) an inevitably far larger and more influential acute trust. Existing PCN Clinical Directors are overstretched and it is not clear now additional activities can be supported and appropriately resourced.

A key element in this proposal is financial allocation and delegation. One practitioner shared “I am not reassured by mentions of a “single pot” (2.40) nor by the vagueness of delegation of financial decisions to “place”. (2.43). I suspect primary care influence will be relegated to “place” level and the major decisions made by the powerful trusts in the ICS.”

Option 2 refers to “conflicts of interest” however it is not clear how these measures would converge with other legislative proposals floated, including a reduction in procurement regulation and scrutiny. One LMC representative comments that one of the reasons primary care and general practice was able to respond in such a quick and effective manner to the Covid-19 crisis was that the NHS procedures regarding diversion of budgets etc was flexible. They went on to express concern that the mandatory governance role for local government contrasted with the omission of local general practice provider representation in the form of LMCs, adding “we will find that all such flexibility is lost as the accountants and financial staff in the LA will be scrutinising every proposal, all in the context of what the local political, not clinical, need will be. The Acutes will get away with whatever they want … but General Practice will be targeted.”

Another commented that “Integrated Care Systems, with their control total budgets and their emphasis on system integration are a further step down the road to US style HMOs ... Integration is a buzz word that it is hard to disagree with, they are clever to use it! Who could argue against collaboration around the patient, of course we all want to do that, but they use it to cynically push their agenda. We will be in systems with all of the other players, acute trusts, community health services you name it, all vying for our share of the pot, which of course will be woefully short of the funds needed to provide proper health care for our populations.”

Alongside this view seeking document, practitioners are being advised that “following the ICS next steps document published by NHSEI last Thursday, legislation is likely early next year that would effectively mean that CCGs would be abolished by April 2022, with CCG functions being moved to ICSs that would in turn

become statutory bodies. As such, whilst the CCGs can provide assurance during 2021/22 in several the areas you have set out, they cannot commit successor bodies to anything beyond March 2022. This would be especially difficult if, as the ICS next steps document indicates, ICSs are formed on larger footprints from April 2022 than is currently the case". The suggestion that smaller provider contracts could be unilaterally culled or abbreviated in this way adds to the sense of inequity and dictation rather than collaboration expressed by some GPs

At least one London area has very clear concerns about the likelihood of the muting or diminishment of the GP "voice", as well as the language being used in discussions around ICS creation, including that GPs will have to "prove our leadership as GP's" which connotes an inequitable relationship from the get-go.

Further points made by London practitioners regarding the documents proposals around engagement and collaboration highlighted the diverse and portfolio workforce and work patterns found within London general practice. We remain concerned that the focus on organisations and scale excludes the pool of very experienced clinicians working outside of a PCN who may wish to contribute to the system, such as locum or sessional GPs or nurses and other health care professionals who may not be employed in a PCN grouping and are currently able to add value through local health planning and coordination via Local Medical Committees or CCGs.

### 6 Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

Strongly disagree

**If you have any specific comments or additional information to provide, please provide it in the text box below::**
This document raises significant concerns for primary care. Not only does the centralisation of contracts and commissioning power and delivery within secondary care led structures implicitly marginalise the presence and power of primary care providers, but it is also potentially undermining for the partnership model of general practice and could have wide reaching effects on the future financial viability of community primary care.

Throughout the document there is a lack of clarity about the mechanism and responsibility for primary care voice and concerns to be considered. Outwith the activities of current LMC networks, there are few occasions where the interests of practices can be raised in a consolidated, considered way. It is therefore concerning that whilst there are several opaque references to primary care leaders and primary care leaders (2.17 "a leading role for clinical primary care leaders through primary care networks"; 2.24 clinical and professional leadership; 2.25 "place-based partnership"; 2.31 Primary care provider leadership) these leadership roles and positions are undefined, not explicitly associated with provider voice, and not identified as activities expected of the statutory local representative committee representatives.

Another practitioner expressed the following concerns: "there is risk of vertical integration ie merging of primary and secondary care when you think about place-based care. What does this mean for the GMS contract and for the partnership model? How can practices that are providing excellent care continue to thrive and patients who have unequal access to care also be better served? Is there a risk of levelling down?" Whilst a further practitioner commented on the scale of the new bodies' responsibilities and scope, saying: "I also worry about primary care representation at the different levels – who would this be and where does it come from? Are these the CD reps from the place-based offer? Are they part of the provider alliance or is that not primary or community? And how many reps are there – how is this proportionately represented? One rep for all of general practice is madness."

The proposals set out in the document are significantly different, described as "almost contradictory" by one practitioner, to the aspiration set out at the inception of PCNs less then two years ago of PCNs, and the suggestion that mandatory participation not be extended explicitly to provider representatives from general practice is unacceptable.

Whilst s2.4 reference "mandated representation" of provider organisation who will "help to set" the agenda, it is clear that concerns about inequitable representation of general practice providers are not unfounded. In both the interest of patients and GPs there is a need for greater clarity about the mechanism and responsibility for primary care representatives and their associated voice and concerns to be considered and empowered at the highest levels of the new structures.

The mandatory participation of local authorities would appear to recognise the place-based approach to funding and budgeting, and indicate a preference and supposition of unified budgets with local authorities and others. Were this merely an exercise in budget management and financial acuity that might be largely uncontentious. However, the dismantling of statutory, provider/ member led CCGs means the removal of an automatic seat at the table for GPs. This at a time when GPs and their teams are focussed on Covid-19 and delivering the Covid-19 vaccination ES. One GP commented "… the ICS in our area is formed and needs legislative recognition to mature further. We reflected that working on relationships locally to ensure GPs are embedded in decision making at multiple levels was key." Another added "this option (option 2) … will discourage GP taking partnerships in future and will further demoralised an already beleaguered general practice workforce".

There is some scepticism that the "meaningful delegated budgets to join up services (1.16)" referenced for primary care, community health and mental health services, social care and support, community diagnostics and urgent and emergency care working together will adequately reflect the growing needs of general practice, and questions about the determination of "meaningful" by governance structures believed to be lacking in meaningful general practice representation.

By stating that ICS should include PCN representation in their partnership board and 'other governance arrangements', and a 'primary care perspective' at system level, it is not clear who will be responsible for this 'primary care perspective' at ICS level, nor whether the partnership board is the ICS board itself or a board, with or without delated decision-making authority, in the lower governance structure of the ICS.

Along with representatives from other sectors, primary care representative will be responsible for joint decision making and owning and driving forward the ICS system plan; operating within and in accordance with the triple aim duty. Again, it is not clear whether this decision-making authority is as a member of the ICS board and therefore who has the primary care representative responsibility, whether this will be delegated and if so to what and whom.

### 7 Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

Strongly disagree

**If you have any specific comments or additional information to provide, please provide it in the text box below::**
It is clear that there are currently interface issues between primary and secondary care, but London GPs firmly believe that these issues are best resolved by effective partnership working and collaboration, rather than the delegation or transfer of primary care service commissioning to ICS.

Londonwide LMCs is concerned at proposals for significant transfer of services currently commissioned by NHSE to ICS. Particularly considering the absence of explicit and mandatory primary care representation in governance arrangements (see response to question 6). It is unclear which organisation will hold GP contracts under the proposed reforms, or what the representative and negotiative relationships will look like, or how those holding these commissioning duties will engage with statutory local representative committees. Whilst option one appears to clarify that the single, system-wide CCG will potentially hold those contracts, under option two, the stated “preferred option”, this has not been made clear, although given the wider focus within the proposals – and elsewhere – on devolving power to ICSs and ‘place’ level, it is likely that under option two these powers would pass onto ICSs. The evidence base for the statements associated with option 2, including “streamlined assurance structures” (para 1.7) and “better manage acute healthcare” (4.4), is lacking and we believe there is need for a robust impact assessment.

We are concerned that NHSE are “clear that they want ICSs to be key bodies for financial accountability and financial governance arrangements will need to reflect that”. The intention to create a single pot which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held transformation funding that is allocated to systems and empowers ICS leaders, working with provider collaboratives, with the freedom to distribute those resources with no guarantee or ring fence for general practice funding is a matter of concern.

Primary care investment guarantees are referred to but without significant further assurance, there is clearly significant risk that there will be disinvestment from practices or unreasonable demands. It states that ICS leaders will also have a duty to ensure that they deploy the resources available to them to protect the future sustainability of local services. However, a full understanding of the services is required to ensure that they are adequately protected. There is a risk that they only miss something once it is gone.

Whilst the document’s intention is to simplify care for our patients and to remove bureaucracy the commissioning function does not seem essentially different in that it is still controlled by the same commissioners, but simply in a different organisational structure.

The document outlines that ICS leaders will be expected to use new freedoms to delegate significant budgets some national and regional resources and decision making to ‘place‘ level. And it is argued that it makes sense to devolve a greater share of primary care and improvement resource to this more local level. However, the document states that it will be through their role in ICS leadership that providers will have the opportunity to shape local priorities, and new opportunities – to determine how services are funded and delivered, and how different bodies involved in providing joined-up care work together through lead provider models at place level or through fully-fledged integrated care provider contractual models. This implies that ICS boards will determine the priorities, level of funding and contractual model and place-based boards will decide how the funding is deployed amongst the providers.

There will be greater focus on population health and outcomes in contracts and collective system ownership of the financial envelope, and ICS will also be expected to agree and codify how financial risk will be managed across places and between provider collaboratives. Therefore, given that the accountability for financial balance will sit with the ICS board, and that the demands and expectations of the NHS outstrip resources, financial risk will move from commissioner to providers and the sharing of this risk across providers will be determined by the ICS board.

It is very clear that the intention is that the ICS Board will be the decision-maker regarding service planning, funding allocation between providers, the contractual model, delegation of decision making to ‘place’ based levels, local priorities and intervening if provider do not comply with their plans. Poor decision making will have a significant impact on services, quality, performance and financial viability of providers, and yet the clinical leadership and decision-making authority is very unclear.

The NHS is increasing relying on quantitative data to drive service improvement, and there seems to be little understanding of the value of aspects of care that are not easily measured, such as the doctor patient relationship, continuity of care and relationship continuity. There is significant risk that, without GP leadership, the full complexity of general practice and the value to patients is not understood and lost to the significant detriment to patient care and community health.

Furthermore, the NHS is increasingly focused on large scale organisations. NHS publications have ceased to refer to practices as entities and only refer to PCNs. Staff who would be able to add greater value to individual practices are having to be shared across PCNs and contracts that would be best delivered at practice level are offered to PCNs despite PCNs not being organisational entities in most cases, resulting in complex lead practice models with the option of subcontracting back to practices. Local practices are very good value for money and having autonomy to deliver care in the way that they best see fit enables local need to be meet in the most appropriate way for that community. Local practices also offer greater opportunity for continuity of care.

The repeated emphasis of the role of Primary Care Networks, (pg 6, 7, 9, 12) without recognition that PCNs are formed out of a voluntary sign-up to an Enhanced Service, to which some practices have not signed up, and from which some practices may withdraw over time, is concerning and suggests a lack of understanding that within each place, services are delivered by General Practices, either individually, or where appropriate, in collaboration with other Practices or local partners, which may be, but not exclusively through a PCN.

We would do well to learn from our learning during the recent Covid-19 pandemic regarding:
- The need for clinical prioritisation;
- The need for united clinical leadership –managing relationships and poor decisions at interfaces;
- The impact on health inequalities and the increased importance of GPs within the community; and
- The need for informed, practical and current clinical leadership to inform decisions, and with the power and autonomy to act in an agile way and adapt to circumstances as required.