Cambs LMC
Representing • Supporting • Advising

Contact: office@cambslmc.org
Website: www.cambslmc.org
Tel: 01954 268156

Chief Executive: Dr Katie Bramall-Stainer
Chair: Dr Diana Hunter

NHS England
PO Box 16738
Redditch
B97 9PT
england.legislation@nhs.net

7 January 2021

Our Ref: Cambs LMC ICS System Response 070121
Your Ref:

Integrated Care System (ICS) Engagement Exercise

Response sent on behalf of the local GP profession of Cambridgeshire & Peterborough - comprising the LMC, the PCN CDs and the three GP Federations:

- Cambridgeshire Local Medical Committee Ltd
- The elected representative members of Cambs LMC
- The PCN clinical directors of Cambridgeshire and Peterborough CCG
- Greater Peterborough Network GP Federation
- Cambridge GP Network Federation
- West Cambs GP Federation

1. 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?

   Potentially, but it remains critically important that significant risks outlined in our response are mitigated.

Specific comments or additional information:

I. GPs have historically been, and continue to be, at the heart of the NHS delivery of primary care. It is apparent that the proposals in this document have potentially very significant implications for that, as well as for the autonomy, role and funding of general practice in the future. As this is a matter which may materially affect GPs, and as general practice is the golden thread running through every patient's experience of the NHS, it is crucial that general practice has an opportunity to be heard, and to be central in any legislative proposals.

II. Of particular note, is that the document makes only three references to General Practitioners, and each are all in the context of divergence from a GP-led model under the HSCA 2012 reforms. We note that it makes no reference at all to the GP independent contractor model and the maintenance of patient lists with GP practices, which has been the cornerstone of

NHS patient care since 1948. Collectively, we consider to be a quite staggering omission from any document purporting to describe any future structure of the NHS. Whether proposed changes are with or without merit, they carry huge significance for the delivery of primary care in general, and for general practice in particular.

III. It is also notable that the document is not a formal consultation but an 'engagement process'. We are disappointed that the consultation period is too short at a time when general practice, which serves as the primary NHS experience for 90% of its patients, is concluding delivering the largest influenza vaccination schedule in the history of the NHS; is in the process rolling out the Covid vaccination schedule; is managing Covid in the community alongside exceptional winter pressures and secondary care transfer from overwhelmed Acutes; is managing the risks of an historic backlog and delay in accessing secondary and specialist care for patients; all whilst practising a new SOP via remote first delivery of care across a bank holiday period.

IV. We both note and support the argument made by the GPDF:

> "*NHS England has a statutory duty under section 13Q of the National Health Service Act 2006 to involve the public by information and consultation about changes to service delivery, as well as a common-law duty as a public body to consult with those potentially affected by changes it proposes. It must observe the long-established Gunning Principles, recognised since 1985, including that consultation should allow adequate time for consideration and response. A similar approach emerges from the Cabinet Office Principles, last revised in 2018. The overriding point is the need for proportionality of the type and scale of any consultation to the potential impacts of the proposal decision being taken, and thought should be given to achieving real engagement rather than following bureaucratic process. Specifically noted, at point E, is that consultation should last for a proportionate length of time, and at point G that when a consultation period spans a holiday period consideration should be given to the effect of that, and the possible need to extend the period.*"

Whilst the ICS Engagement team of NHS England have stated in reply that in the circumstances, they believe they "*do not have any legal duty to consult, whether under section 13Q or at common law*", we feel this makes a mockery of any such engagement process and is deeply regrettable.

V. With regard to the two options outlined in section 3 of the paper, NHSEI's clear preference for option 2 is in part because it will replace the "current GP-led CCG model" (NHSEI's description) with a board of representatives from the system partners. The proposals thus clearly offer a fundamental change to the way primary care is organised and its funding allotted. The system would move from one where GPs are supposed to have a leading role, to one where GPs will be just one voice among many, potentially with a significantly reduced role and influence. The central importance of our gatekeeper model which allows the NHS efficiencies to the tune of billions of pounds per annum, is given scant regard.

VI. Whilst option 2 suggests measures that arguably simplify bureaucracy, it also both increases centralisation and potentially dilutes the voice of general practitioners at board level. The removal of mandatory GP provider membership in the proposed newly legally configured structures (cf question 6), weakens independent scrutiny, and dilutes an authentic patient-centred voice.

VII. 'Bottom-up' reforms and a greater emphasis on local decision making are to be cautiously welcomed, but there is little meaningful discussion around those ICS footprints who stand to inherit a significant deficit; where that deficit arises; and how that deficit will be managed moving forwards where the 'distance to target' is set to grow.

VIII. There is an absence of a formal role in both oversight and clinical governance. Our questions arise from a legitimate concern that in certain footprints such as our own, the power of large acute trust partners, and monopoly community providers, could risk diminishing objective commissioning, and potentially undermine the autonomy and voice of general practice. The challenge for primary care is in its unconsolidated nature – Cambridgeshire & Peterborough is comprised of c90 practices, across 21 PCNs with multiple sites and approximately 700 GPs with countless team members providing >450,000 care episodes a month for our population of just under a million. Given the scale of care that general practice provides, it is extraordinary to note the absence of mandatory general practice representative voices in the ICS governance arrangements shared by NHSEI thus far.

IX. The collective voice of Cambridgeshire & Peterborough general practice wishes to see an ICS that cherishes the role of the independent contractor status; that facilitates the transformation of care into being closer to the patient in the heart of their community. At scale GP-led provider organisations and newly created PCNs need to have a voice at an ICP and ICS level, supported there by the LMC with its statutory authority to represent general practice and provide support and advice to the ICS board. Locally in Cambridgeshire and Peterborough, we are fortunate to have a strong Alliance (nascent ICP) co-chair model, in which a provider voice from an LMC GP leader has proved to be essential. 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 upon the support provided by a robust and collaborative LMC - able to provide a consolidated and considered voice of a united general practice local profession, to wider system partners.

X. We are concerned to see scant reference to general practice leadership within the ICS structure, which is poorly defined, fails to be intrinsically tied into a provider voice, and where the statutory local representative committee enshrined in successive NHS acts is paid regard (cf 2.17; 2.24; 2.25; 2.31).

XI. When ICSs were first mooted, the British Medical Association considered five operating principles:

- Protect the partnership model of general practice and GPs' independent contractor status
- Ensure the pay and conditions of all NHS staff are fully protected
- Only be pursued with demonstrable engagement with frontline clinicians and the public, 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.

XII. Whilst there is nothing explicit within the engagement document that will directly alter the independent contractor status of GPs, the proposals raise questions about the direction of travel. It is our belief that any future ICS must seek to focus on the skill, flexibility and efficiency shown by general practice in how a system can adapt and foster resilience. The financial models proposed favour episodic care. There should be an opportunity here to look at the economic necessity of developing funding streams that reward continuity of care and genuine integration.

XIII. Finally, we would ask that legislation be made with due process, due diligence and great care. We are in the midst of the greatest challenge to face the health economy in a century, which will have implications and ramifications beyond the next 12 months. We would suggest that system priorities are better focused on locally responsive plans, and to allow a longer period prior to making statutory changes.

2. 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

Specific comments or additional information:

I. We have sought feedback from across the profession: our constituent GPs and practices; GP federations; and on 17 December 2020 the LMC held a meeting for both LMC members and PCN clinical directors to consider the proposals:

II. Section 2.5 specifically refers to vertical integration without further commentary around how the nascent PCN structure may influence a provider collaborative containing a large or influential acute, community or specialist trust. PCN Clinical Directors are overstretched and any additional development in such an area would require significant LMC support and appropriate additional system resource.

III. Whilst PCNs need an integral local voice, the omission of the statutory representative and collaborative professional voice of general practice, the LMC, is unwise. Some ICSs such as Cambridgeshire and Peterborough recognise the essential role of the provider voice in primary care leadership. 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 upon the support provided by a robust and collaborative LMC supporting them in turn - able to provide a consolidated and considered voice of a united general practice local profession to wider system partners.

IV. We note how finances are to be increasingly organised at ICS level (para 2.39) with the creation of a single pot including current CCG budgets, primary care budgets, specialised commissioning spend, central support, sustainability funding and nationally held transformation funding (para 2.40). We also note the potential for current CCG functions being absorbed to become core functions of integrated care systems (para 2.64). NHSEI's clear preference for option 2 is in part because it will replace the current 'GP-led CCG model' with a board of representatives from the system partners. The proposals thus clearly offer a fundamental change to the way primary care is organised and its funding allotted.

V. The system would move from one where GPs are supposed to have a leading role, to one where GPs will be just one voice among many, potentially with a significantly reduced role and influence. The challenge for primary care is in its unconsolidated Cambridgeshire & Peterborough is comprised of c90 practices, across 21 PCNs with multiple sites and approximately 700 GPs with countless team members providing >450,000 care episodes a month for our population of just under a million. Given the scale of care that general practice provides, it is extraordinary to note the absence of mandatory general practice representative voices in the ICS governance arrangements shared by NHSEI thus far.

VI. There is a paucity of detail around financial allocation and delegation. Importantly, the funding for primary care will no longer be separate from the single pot which the leadership of the integrated care system will disburse as it sees fit (para 2.4). General practice commissioning and planning needs to occur at system level alongside equally major decisions led by trust partners on an equitable basis. Option 2 goes on to refer to "conflicts of interest," yet other proposals include a commitment to reduce procurement regulation and scrutiny, and a dilution around competition in the interests of making the best use of the public pound.

VII. In Spring 2020 we saw the overnight transformation of the service model of delivery of general practice with IT innovation and estate utilisation due to flexibilities in how budgets were managed. It is our belief that any future ICS must seek to focus on the skill, flexibility and efficiency shown by general practice in how a system can adapt and foster resilience. The financial models proposed favour episodic care. There should be an opportunity here to look at the economic necessity of developing funding streams that reward continuity of care and genuine integration.

VIII. We would seek to highlight the lack of engagement and collaboration in this paper. We encourage NHSEI to extend this period to facilitate a richer source of feedback. GPs embody a diverse portfolio workforce with experienced clinicians working in varied and complex roles throughout the system 24/7, whose skill and aptitude may be lost. Likewise, there is a groundswell of established experienced business leaders and primary care champions, expert generalists in our teams of nurses who may not be employed within PCN groupings, but who need to be able to add value and insight into local health planning and community strategies.

3. 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

Specific comments or additional information:

I. This document raises significant concerns around the centralisation of both commissioning and contracting processes, alongside delivery within secondary care led structures which implicitly marginalise the presence and power of the less consolidated voice of general practice and community providers. The challenge for primary care is in its unconsolidated nature – Cambridgeshire & Peterborough is comprised of c90 practices, across 21 PCNs with multiple sites and approximately 700 GPs with countless team members providing >450,000 care episodes a month for our population of just under a million. Given the scale of care that general practice provides, it is extraordinary to note the absence of mandatory general practice representative voices in the ICS governance arrangements shared by NHSEI thus far.

II. So too, is there a potential for undermining the partnership model of general practice which could potentially have significantly deleterious effects on the future financial viability of community primary care which would cost an ICS dearly in terms of caretaker APMS provision, estate and premises, patient movement and loss of continuity. This loss of continuity has the potential to be highly detrimental to doctors and patients alike - continuity and co-ordination is essential for safe, effective and high quality care and provides unarguable financial efficiencies.

III. Throughout the document there is a lack of clarity about the mechanism and responsibility for general practice commissioning, contracting, budgeting and representation. Outside the remit of the LMC, there are precious few opportunities to align the interests of member practices, or to raise their concerns, in a consolidated manner. We are concerned to see scant reference to general practice leadership within the ICS structure, which is poorly defined, fails to be intrinsically tied into a provider voice, and where the statutory local representative committee enshrined in successive NHS acts is paid regard (cf 2.17; 2.24; 2.25; 2.31).

IV. Para 2.4 references "mandated representation" of provider organisations who will "help to set" the agenda. We need to see clarity around the mandated voice of general practice professional and provider representation at each level. We note the mandatory participation of the local authority which recognises the place-based approach to funding and budgeting, and thus one could imply, indicates a preference to unified budgets with local authorities and others. Whilst 'Bottom-up' reforms and a greater emphasis on local decision making are to be cautiously welcomed, there is little meaningful discussion around those ICS footprints who stand to inherit a significant deficit, where that deficit arises, and how that deficit will be managed moving forwards where the 'distance to target' is set to grow.

V. There is an absence of a formal role in both oversight and clinical governance. Our questions arise from a legitimate concern that in certain footprints such as our own, the power of large acute trust partners, and monopoly community providers could risk diminishing objective commissioning, and potentially undermining the autonomy and voice of general practice. When seen in tandem with a clear preference to legislate for the demise of the statutory provider/member led CCG, there is seen to be a dilution in representation of the general practice voice, and this urgently needs clarification.

VI. A particular concern is around the sentiments described in para 1.16, that is, "meaningful delegated budgets to join up services" around primary care; community health and mental health services; social care and support; community diagnostics and urgent and emergency care working together. We question how this will adequately reflect the growing needs of general practice, and how it could potentially smother nascent PCN structures' autonomy at a place level, if insufficient general practice leadership is embedded at both place and system.

VII. The paper remarks that the ICS should include PCN representation at the partnership board and 'other governance arrangements', and a 'primary care perspective' at system level, however it is far from clear how a system-level PCN perspective will be sought; who will be responsible for it; whether the ICS board will have delegated decision-making or budget-setting authority.

4. 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

Specific comments or additional information:

I. In November 2020, Cambs LMC published its Covid 19 Capacity and Workload Transfer Report into general practice. It did this in collaboration with LMC partners from Beds and Herts across three ICS footprints covering a population across the East of England of 3.6 million

patients. It was clear from the data that the primary-secondary interface remains a critical system challenge. See: https://cambslmc.org/wp-content/uploads/2020/11/Covid-19-GP-Capacity-Report-Beds-Cambs-Herts-LMCs-Nov-2020.pdf

II. Our research and commentary are clear, that the ICS model provides an opportunity to embrace collaboration to ensure a more efficient system of delivery of care for our patients, rather than a delegation or transfer of primary care commissioning to an ICS level.

III. A transfer of services from NHSE to ICS would include inheriting a fractured primary care dentistry model and the complexity of community pharmacy and optometry contracts and services.

IV. A critical concern is the lack of clarity over which organisation will hold GP contracts under the proposed reforms, and how those holding commissioning roles will engage with statutory local representative committees.

V. Option 1 clarifies the single, system-wide CCG holding the contracts. Meanwhile the "preferred option" of option 2, is much less clear and implies devolving power to the ICS board. There is a lack of evidence base for option 2. Necessary detail around "streamlined assurance structures" (para 1.7) with a lack of clinical governance and oversight is a concern. Para 4.4 references how the ICS can "better manage acute healthcare" (4.4) without any timeline, options appraisal or impact assessment.

VI. Para 2.39 describes the creation of a single pot including current CCG budgets, primary care budgets, specialised commissioning spend, central support, sustainability funding and nationally held transformation funding (para 2.40). We also note the potential for current CCG functions being absorbed to become core functions of integrated care systems (para 2.64). The proposals thus clearly offer a fundamental change to the way primary care is organised and its funding allotted. The system would move from one where GPs are supposed to have a leading role, to one where GPs will be just one voice among many, potentially with a significantly reduced role and influence. The challenge for primary care is in its unconsolidated nature – Cambridgeshire & Peterborough comprises c90 practices, across 21 PCNs with multiple sites and approximately 700 GPs with countless team members providing >450,000 care episodes a month for our population of just under a million. Given the scale of care that general practice provides, it is extraordinary to note the absence of mandatory general practice representative voices in the ICS governance arrangements shared by NHSEI thus far.

VII. Whilst primary care investment guarantees are referred to, there is no explicit budget, ring-fencing, or assurances for the general practice financial allocation. What will prevent significant disinvestment from practices in the face of serious system deficits? Whilst we note 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" alongside "simplifying care for our patients" and "removing bureaucracy from commissioning" - there is an implication that ICS boards will determine the priorities; level of funding and contractual models; and that place-based boards will decide how the funding is deployed amongst the providers. Financial risk will have to be managed across the system, between places and among provider collaboratives. If financial balance sits with the ICS board, the financial risk will move from the commissioner to the provider(s).

VIII. 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, and at present does not explicitly include general practice - which poses an exceptional risk for the GP partners holding contracts.

IX. One can only commission well, that which one fully understands - but there seems to be little understanding of the value of aspects of care that are not easily measured, such as the doctor-patient relationship, practice stability and continuity of care. There is a significant risk that, without GP leadership, the full complexity of general practice, and inter alia, community and population health outcomes and patient-value is not understood and potentially lost.

X. The proposals thus clearly offer a fundamental change to the way primary care is organised and its funding allotted. The system would move from one where GPs have a leading role, to one where GPs will be just one voice among many, with a significantly reduced role and influence. Importantly, the funding for primary care will no longer be separate from the single pot which the leadership of the integrated care system will disburse as it sees fit. We seriously question whether this reduced role and influence for General Practitioners can be in the best interests of patient care.

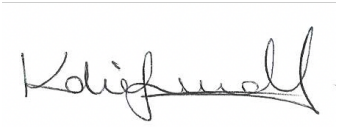
XI. Of particular note is that the document makes only three references to 'General Practitioners', and these are all in the context of moving away from a GP-led model. We note that no is made at all to the GP independent contractor model and the maintenance of patient lists with GP practices, which has been the cornerstone of NHS patient care since 1948 and which we consider to be a staggering omission from any document purporting to discuss any future structure of the NHS. Whether the proposed changes are with or without merit, they are clearly hugely significant for the delivery of primary care generally, and for general practice in particular.

XII. It is in this context that we observe how the NHS is increasingly focused on large scale organisations. NHS publications have ceased to refer to practices as entities, preferring to refer to PCNs. Primary Care Networks have a repeated emphasis, (pages 6, 7, 9, 12) without the recognition that these structures are based on a voluntary annual Direct Enhanced Service contract, to which some practices have not signed up, and from which some practices may withdraw or change over time. This is concerning as it suggests a lack of understanding.

XIII. The PCN DES may have led to additional staff, but this has been far from uniform. Away from a practice level, PCNs are contracted in a variety of ways, with numerous lead provider models and subcontracting arrangements. General practice offers exceptional value for money in its gatekeeper role for the NHS, inter alia, the ICS. Its autonomy to deliver care in the way best tailored to the practice population should not be feared but celebrated. It is vital therefore that this latest reorganisation recognises the value that general practitioners in their role as community expert generalists currently bring. It may be inconvenient having independent thinkers with a long view in the system - but general practitioners have created astonishingly cost-effective way of providing population-based care at a personal level over generations. It is easy to take this achievement for granted, but it exists because we have made it happen.

For the ICS to truly succeed:

- Celebrate the autonomy and efficiency of the partnership model of general practice
- Mandate ICS and ICP roles for statutory representative committee voices
- Commission with intelligence and knowledge of the full gamut of the NHS landscape - drive the agenda to move care and resources out of hospitals and closer to the patient
- Use innovations learnt during the pandemic to share data, and redesign hospital and community care pathways around the patient, with general practice as the golden thread
- Prioritise clinical need - focus on the risks at the primary/secondary care interface where initiatives are not without merit – but all are taking place at the expense of primary care.
- Collaborate with authenticity: ensure that the impact of any new policy or transfer of workload is considered at a system level, particularly with regards to ensuring resources are directed to where the work is undertaken
- Focus on health inequalities and the increased importance of continuity of care in the context of population outcomes
- Manage conflict of interest and governance with statutory guidance
- Champion the role of the informed, practical and agile clinical leader - with power and autonomy to adapt to secure a resilient system, in particular that of the expert generalist: the GP



Dr Katie Bramall-Stainer *MBBS MRCGP (2008) DFRSH DRCOG BSc (Hons)*
Chief Executive, Cambs LMC Ltd

Reply to: katie@cambslmc.org