GPDF Listening Supporting Influencing

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Our Ref: NHS ICSC GPDF Response
Your Ref:

7 January 2021

Dear Sir/Madam,

Re: INTEGRATED SYSTEMS CONSULTATION

The General Practitioners' Defence Fund (GPDF) exists to ensure representation, influence and support for Local Medical Committees (LMCs), GPs and general practice throughout Great Britain.

What follows is our detailed response to the joint NHS England and NHS Improvement (NHSEI) consultation, of 26th November 2020, entitled *Integrating Care: Next steps to building strong and effective integrated care systems across England.*

Thank you for your response, of 31st December, to my letter, of 22nd December, regarding the process and timeframe for the consultation. I find it difficult to believe that the Department of Health and Social Care (DHSC) would not have informed NHSEI precisely when it intends to introduce legislation to Parliament, especially since the likely contents of the Bill(s) will have significant consequences for NHSEI. None of this should obviate the need for the appropriate consultation process that I set out in my letter.

Your response does not in fact address the points made about why the consultation period is, at the present time and in the present circumstances, utterly inadequate. You have offered a reason for the choice of deadline but have not sought to explain how that will enable a realistic consultation process to take place. You have suggested that you have in fact no duty to consult, a position which we unhesitatingly reject. Even on the unlikely supposition that you regard yourself as undertaking this consultation on a purely voluntary basis you have a clear duty as a public body to ensure that any consultation you do undertake is fair and reasonable, in line with the guidelines noted in our earlier letter. We renew our invitation to you, even at this late hour, to recognize the reality of the present situation and extend the consultation period. Our position about the merits and effectiveness of the present consultation is fully reserved.

Our experience of previous 'engagement sessions' suggests that you will likely receive the answers you were seeking, rather than any genuine debate about the proposals. I note that the BMA and LMCs were absent from the list of stakeholders mentioned specifically in your email. In addition, most GPs will have been too busy to participate, assuming that they even knew about the engagement sessions at all.

We have consulted LMCs and the responses vary due to their location and the nature of the existing relationships with local NHS management. However, an element common to all responses is that there is clear evidence of 'change fatigue,' especially when the country is in the grip of the worst pandemic in a century.

We strongly disagree with the four specific proposals in the consultation. For the legislation enacting the ICS structure to truly succeed we believe it needs to:

- Include the mandatory representation of Local Representative Committees to an ICS and to Places within an ICS;
- Define the autonomy of the partnership, registered list model of general practice through a ring-fenced budget;
- Establish a funding structure which genuinely follows the patient and enables the transfer of resources out of hospitals, facilitating the redesign of hospital and community care pathways to eliminate health inequalities;
- Place a statutory duty on all ICSs to manage any conflicts of interest of Board members and employees;
- Place a statutory duty on an affected ICS to 'rural proof' all of its policies and provision of services.

Include the mandatory representation of Local Representative Committees to an ICS and to a Place

1) The Government came to power in May 2010 on a promise that it did not intend to conduct any reorganisations of the NHS. Having spent the period 2010-13 conducting just such a reorganisation that was, according to the then Chief Executive of the NHS, "*so large that you can see it from space*," the Government's manifesto in 2019 was silent on the structure of the NHS. We feel that there is, therefore, no mandate for the changes being proposed, which are of a size that could be viewed with ease from the International Space Station.
2) As I pointed out in my letter, of 22nd December, the proposals in the consultation document envisage a fundamental change in the way that primary care is organised and its funding allocated. The new system moves away from one in which GPs have a leading role, to one where GPs will be just one voice among the many and with a significantly reduced role and influence.
3) The experiences of some LMC officers involved as members of the 'shadow' ICS boards are not encouraging. They report that there is little interest in, or understanding of, primary care from the more numerous representatives of secondary care providers. Others inform us that they have established productive relationships, which have led to positive changes for patients; that is, of course, against the current background where ICSs are not on a statutory footing and have to function collaboratively, a very different matter from what is now proposed.
4) CCGs are GP member-led organisations with written constitutions. When significant constitutional changes are proposed, it is usually the case that a two-thirds majority of the members must vote in support of them. The consultation document is silent on this point and we would expect, at the very least, that CCG members should be invited to vote on changes of the order of magnitude being proposed.
5) We endorse neither option set out in the consultation for the future of CCGs. The choice presented is not genuine, given the clear preference for option 2 in the proposals and the significant impact on CCGs caused by either approach.

6) Instead, we support the BMA's call for the key, positive elements of CCGs, such as a strong clinical voice, local decision making, and accountability to clinicians to be retained in any new model.

7) Following on from this, there is, therefore, unanimous support for the repeal of Section 75 from the Health and Social Care Act 2012. In addition, LMCs are strongly of the view that the powers of the Secretary of State for Health and Social Care, Ministers and Departmental civil servants should be restored over NHS England and NHS Improvement (NHSEI) as soon as it is practically possible.

8) We note the use of the phrase 'operational independence' for NHSEI in the document. A number of our respondents were concerned about this, as it implies no real change from the current unsatisfactory position. The Secretary of State and DHSC must have powers of control and direction over the NHS, as was the case prior to 2013. The current process, involving the setting of a 'mandate' for NHSEI, is largely meaningless and not subject to proper scrutiny, or accountability.

9) There is, surprisingly, no mention of geographic boundaries for the proposed ICS bodies. One county-wide LMC has pointed out that the changes will result in three separate NHS bodies, two of which cross boundaries into other counties. This has already attracted negative comment from the local authorities and LMCs affected.

10) In addition, whilst option two of question four suggests measures that could 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 structures (question 6), weakens independent scrutiny and dilutes an authentic patient-centred voice.

11) There is an absence of a formal role in both oversight and clinical governance for GPs and other primary care contractors. This is a legitimate concern, especially where the power of large acute/foundation trusts, and monopoly community providers, could risk diminishing objective commissioning, and undermining the autonomy and voice of general practice. Given the scale of care that general practice provides, it is unbelievable that there is an absence of a mandatory general practice representative voice in the ICS governance arrangements shared by NHSEI thus far.

12) Whilst PCNs need an integral voice, the omission of the statutory representative and collaborative professional voice of general practice, the LMC, is unwise. Some of the emerging ICSs such as Cambridgeshire & Peterborough, and those in Wessex, 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. This will ensure that there is a consolidated and considered voice of local general practice.

13) LMCs have expressed concern that there is little reference to general practice leadership within the ICS structure. This is considered to be poorly defined and does not have regard to the activities expected of a statutory local representative committee enshrined in successive NHS Acts. (paragraphs 2.17; 2.24; 2.25; 2.31). Clearly, the size and scope of an ICS will vary due to geography and the size of the population. Some LMCs have suggested that IC partnerships at a local level (Places) should be coterminous with LMCs.

14) With regard to the mandatory participation of NHS Bodies and Local Authorities, the legislation must also specifically include all of the Local Representative Committees; there must be no dilution of the role of LMCs and GPs.

Define the autonomy of the partnership, registered list model of general practice through a ring-fenced budget

1) LMCs represent GPs covering a broad spectrum of communities, from the densely populated major cities and towns, to the most remote and rural parts of the countryside. No one area is the same and neither are the practices that serve them. Many of them pre-date the NHS. The one thing they all have in common is that they are part of the local community. They are the 'front door' to the NHS where ninety per cent of patient interaction takes place, via the registered list.

2) Surprisingly, there are only three references to general practitioners in the entire document, and these are all in the context of the divergence from a GP-led model under the reforms implemented since 2012. We note the absence of any reference to the GP independent contractor model and the maintenance of patient lists with GP practices, which has been the hallmark of NHS patient care since 1948 and which we consider to be a significant omission from any document purporting to discuss the structure of the NHS.

   In your email, of 31st December, you stated that:

   "The proposals we are engaging on do concern CCGs and the role of GPs in ICSs and commissioning of secondary care, but they are not about the specific structure or model under which primary medical care is commissioned. Our current proposal, on which we seek feedback, is to shift the commissioning functions, and does not propose changes to the independent contractor model for general practice or the system of patient lists."

3) The clarification in your email, of 31st December, regarding independent contractor status for GPs and registered lists, is welcomed. However, LMCs remain concerned about the outcome of these proposals. The legislation, accompanying regulations and directions, must allow for ICSs to focus on the skill, flexibility and efficiency demonstrated in general practice in how a system can adapt and foster resilience. Funding should not equate to item of service payments based upon activity. The work of Professor Barbara Starfield, and others, demonstrates the cost-effectiveness of British general practice, based on the registered list and the continuity of care that it allows.

4) So-called 'bottom-up' reforms and a greater emphasis on local decision making have been cautiously welcomed, but there is little meaningful discussion around those ICS areas which stand to inherit a significant budget deficit, where that deficit arises, and how that deficit will be managed in future where the so-called 'distance to target' is set to grow.

5) It is in this context that we note how the NHS is increasingly focused on large scale organisations. NHS publications have ceased to refer to practices as entities and only refer to Primary Care Networks (PCNs). PCNs have a repeated emphasis, (pages 6, 7, 9, 12) without the recognition that these structures are based on a voluntary annual Direct Enhanced Service (DES) contract, to which some practices have not signed up, and from which some practices may withdraw or change over time. The PCN DES may have led to the appointment of additional staff, but this has been far from uniform. Appointments have been across contracts with complex 'lead provider' models and subcontracting arrangements rather than at practice level.

6) General practice offers exceptional value for money in its gatekeeper role for the NHS and, inter alia, the ICS. Its very autonomy allows it to deliver care in the way best tailored to the practice population and should be the hallmark of the new arrangements.

7) Accordingly, there must be a specific ring-fenced budget for general practice in the new arrangements, in addition to a separate primary care capital budget. Otherwise, we are concerned that there will be nothing to prevent significant disinvestment from practices in the face of serious secondary/community care deficits.

   We welcome the statement in 2.41 that ICS leaders will have a duty to distribute resources in line with national rules such as the investment guarantees, but this needs further clarity and underwriting in legislation that such guarantees will continue to be negotiated.

8) We endorse the five operating principles for ICSs established by the British Medical Association (BMA):

   - 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.

Establish a funding structure which genuinely follows the patient and enables the transfer of resources out of hospitals, facilitating the redesign of hospital and community care pathways to eliminate health inequalities

1) Section 2.5 of the document specifically refers to vertical integration without further commentary around how the new Primary Care Network (PCN) structure may influence a large or influential acute, community or specialist trust. How can an NHS Body created around an acute trust avoid having a natural bias towards secondary care? PCN Clinical Directors are overstretched and any additional development in such an area would require significant LMC support and appropriate additional NHS resources.

2) 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, funding for specialised commissioning, 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

9) 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.

3) Of particular concern are the sentiments described in para 1.16, regarding "*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 local level, if there is insufficient general practice leadership.

4) Proposals to transfer, or delegate, services currently commissioned by NHSE to ICS bodies are fraught with difficulty. This is especially so if the service in question is in disarray and/or deficit. LMCs are clearly of the view that the ICS model provides an opportunity to embrace collaboration to ensure a more efficient system of delivery of care for patients, rather than a delegation or transfer of primary care commissioning to an ICS level.

5) Some LMCs pointed out that a transfer of services from NHS to an ICS would include a broken community dentistry model, in addition to the complexity and scale of the community pharmacy contractual framework (CPCF). Parts of the CPCF are the responsibility of the DHSC, especially those aspects relating to drug costs/reimbursement, while other aspects are NHSEI's responsibility. Allied to this is the lack of clarity over which organisation will hold GP contracts under these reforms and how those holding commissioning roles will engage with statutory local representative committees.

6) 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 to support option 2. Necessary detail around "streamlined assurance structures" (para 1.7) with a lack of clinical governance and oversight is of concern. Para 4.4 references how the ICS can "better manage acute healthcare" (4.4) without any timeline, options appraisal or impact assessment.

Place a statutory duty on all ICSs to manage any conflicts of interest of Board members and employees

1) Little thought appears to have been given to conflicts of interest and the governance of an ICS. It may well be that such matters do not need to be written into primary legislation. Nonetheless, how can the public and Parliament be assured that organisations dominated by secondary care providers will avoid any conflicts of interest? The proposals in paragraph 2.44 are a good example of this. What will the relationship be between the Board of a Foundation Trust and the new ICS Board? Moving from the competitive environment of the 'purchaser/provider split' will take more than an NHS plan.

2) It seems clear that there is a desire for ICSs to move towards a US-style Health Maintenance Organisation (HMO) model. However, under an entirely tax funded system, there is a danger that a desire for centralised management control becomes dominant, where only the chosen few are allowed to query, or doubt, the perceived wisdom. As we discovered in the reports of Robert Francis QC into the disaster at Mid-Staffordshire Trust, this breeds a management culture of bullying, and coverup which is not in the interests of patients; Robert Francis said, in his first report, that "*...it should be the patients - not numbers - which counted*."[1] Has this really been debated within NHSEI and, more importantly, Parliament?

Place a statutory duty on an affected ICS to 'rural proof' all of its policies and provision of services

LMCs representing remote and rural communities have pointed out that there is a total absence of any 'rural proofing'[2] of the proposals set out in the consultation. The Department for Environment, Food and Rural Affairs published guidance, in March 2017, to assess the impact of policies on rural communities. Perhaps you could explain why this simple process has not been undertaken. The LMCs affected pointed out that their view is that NHSEI is very London-centric.

[1] Robert Francis QC, Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, Volume 1: Analysis and Lessons Learned, Part 1, p11, 2013.

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/600450/rural-proofing-guidance.pdf

In the spirit of “getting it right the first time”, the GPDF and LMCs are available for further discussions at any point in this process.

Yours faithfully,

Dr D A Möderle Lumb

Chair

mail@gpdf.org.uk

From: LEGISLATION, England (NHS ENGLAND & NHS IMPROVEMENT - X24) <england.legislation@nhs.net>
Sent: 31 December 2020 17:34
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Cc: 'Douglas Andrew Moederle Lumb'; CONTACTUS, England (NHS ENGLAND & NHS IMPROVEMENT - X24); CE, England (NHS ENGLAND & NHS IMPROVEMENT - X24)
Subject: RE: Letter from the Chair of GPDF re Integrating Care: Next steps to building strong and effective integrated care systems across England
Attachments: NHS ICS C.pdf

Categories: GPDF

Dear Dr. Möderle Lumb

Thank you for your letter of 22 December in relation to the most recent engagement exercise initiated on 26 November 2020. Your immediate concern was in relation to the length of this current engagement exercise and the deadline for response.

The issue on which the document sought views was not specifically the arrangements for 2021/22, but primary legislative options. In determining the deadline for responses to the questions posed in the engagement document, it was important to consider the likelihood of when Government might come forward with proposals for primary legislation. This has been signalled both in the Queen's speech and more recently by Ministers. Our deadline was therefore chosen to ensure that feedback from this engagement exercise can be captured in time to feed into any proposals for such a Bill.

We have been running a number of engagement sessions - both in advance of publication of the November document, and then subsequently to take feedback on that document. These have included (but not been limited to) sessions with the NHS Confederation, including NHS Clinical Commissioners and the PCN network, the range of medical royal colleges including the RCGP, as well as voluntary sector organisations, patient groups and various parts of local government. Our wider legislative proposals, referenced in the document, were also considered and broadly supported as part of a separate engagement process in 2019. Models for establishing ICSs were considered as part of that exercise. Whatever the future statutory basis for Integrated Care Systems (ICSs), we will continue to proactively engage on their development as we have done throughout their progression to date.

Your letter also states: "there is no reference whatsoever 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 quite staggering omission from any document purporting to discuss the structure of the NHS". The proposals we are engaging on do concern CCGs and the role of GPs in ICSs and commissioning of secondary care, but they are not about the specific structure or model under which primary medical care is commissioned. Our current proposal, on which we seek feedback, is to shift the commissioning functions, and does not propose changes to the independent contractor model for general practice or the system of patient lists.

Clearly, the final decision on legislation rests with Parliament. Although we are working with the Department of Health and Social Care on potential options, it is for Government to decide on the form of any such legislation introduced to Parliament. Should Government decide to take forward any of our recommendations as part of a wider package, we expect they will continue to engage prior to introduction of a Bill. Upon introduction, the usual process of Parliamentary scrutiny, amendment and approval would follow.

In the circumstances, we do not have any legal duty to consult, whether under section 13Q or at common law. Your feedback is however appreciated and will be considered alongside feedback received from others.

Yours faithfully

ICS engagement team

From: mail@gpdf.org.uk <mail@gpdf.org.uk>
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Cc: 'Douglas Andrew Moederle Lumb' <chair@gpdf.org.uk>
Subject: Letter from the Chair of GPDF re Integrating Care: Next steps to building strong and effective integrated care systems across England
Importance: High

Please find a copy of a letter from the Chair of the GPDF for your urgent attention

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Our Ref: NHS ICS C 1
Your Ref:

22 December 2020

Dear Sir

Re: INTEGRATED CARE SYSTEMS CONSULTATION

On 26 November 2020 NHS England and NHS Improvement jointly issued a consultation document entitled *Integrating Care: Next steps to building strong and effective integrated care systems across England*. This document sets out proposals for the significant extension of the role of integrated care systems in the NHS, proposals which it is apparently intended to result in legislation with effect from April 2022. The consultation is set to close on 8 January 2021. Our immediate concern, leading to the writing of this letter, is over this consultation period.

The GPDF is concerned with the interests of GPs throughout Great Britain. 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, it is crucial that they have the opportunity to be heard.

We note that, at their core, the proposals involve a substantial extension of the role of integrated care systems, with the planning, commissioning and organising of services moving to this level. Associated with this would be the devolution of a greater share of primary care funding and improvement resource to integrated care systems. Among specifics mentioned are:

- Primary care providers working with a wide variety of other services with meaningful delegated budgets (para 1.16);
- A need for system-wide governance arrangements, including a partnership board with NHS, local councils and other partners represented (para 2.29);
- Finances to be increasingly organised at integrated care systems level (para 2.39);
- The creation of a single pot including current CCG budgets, primary care budgets, specialised commissioning spend, central support or sustainability funding and nationally held transformation funding (para 2.40);

- Current CCG functions being absorbed to become core functions of integrated care systems (para 2.64).

When we reach the two options outlined in section 3 of the paper, your clear preference for option 2 is in part because it will replace the current GP-led CCG model (your 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 have a leading role, to one where GPs will be just one voice among many and 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. Of particular note is that the document makes only three references to General Practitioners, and these are all in the context of a moving away from a GP-led model. We note that it makes no reference whatsoever 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 quite staggering omission from any document purporting to discuss the structure of the NHS. Whether the proposed changes are merited or not, a matter about which we have the gravest doubts, they are clearly hugely significant for the delivery of primary care generally and for general practice in particular.

We remind you that 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.

This consultation was launched on 26 November, while England was in lockdown and the NHS generally, and GPs specifically, were trying to address the Covid pandemic and rapidly rising infection rates, all of this occurring as we enter the heart of the flu season. GPs are far from immune to the pandemic themselves and many practices are in consequence short-handed, adding to their difficulties. Further, the consultation spans the period during which the Pfizer vaccine has received approval and become available and GPs have been at the forefront of vaccinations; given the known fragility of the vaccine and the difficulties of transport and storage this has entailed a huge logistical challenge. It spans also the period of Christmas and New Year, with its concentration of Public Holidays in a short space of time, this being also a period when many people take annual leave and many businesses close down for a week or more. The period allowed for responses is 6 weeks and 2 days even though the Cabinet Office guidelines suggest periods between 2 weeks for the simplest matters and 12 weeks for matters of complexity and major impact. The period offered is manifestly too short

for the importance of the matters at stake, even if it were a period when GPs could be expected to have some spare capacity to address the issues. At the time chosen, when they are already at full stretch in this unprecedented situation, the time allowed is wholly unrealistic.

We would remind you that where a duty to consult exists, as it does here, decisions made without first conducting a realistic consultation are, on that ground alone, liable to be set aside via Judicial Review as being made in breach of the common law duty of fairness.

Accordingly we invite you at this stage to accept that the consultation, to be meaningful, realistic and in accord with your public law duty, must be lengthened to give the opportunity for intelligent consideration and reasoned response. Given the importance of the proposed changes we would suggest that this is a matter appropriate for a 12-week period and that the time for responses should therefore be extended to 19 February. It is vital that proposals of this significance not be pushed forward without a proper opportunity for all views to be put forward and considered. This cannot be achieved without such an extension.

We must further ask for your urgent response to this request. If we have not heard from you agreeing to the extension by the end of this month, we shall have no alternative but to urgently consider what further steps to make, including possible applications to the Court.

We trust that you will see the good sense of this proposal, in line with the emphasis nowadays on "getting it right first time". We therefore await your prompt and positive response.

Yours faithfully

D A Möderle Lumb
Chair

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