House of Commons Health and Social Care Select Committee

Integrated Care Systems: autonomy and accountability

Inquiry response from the Pharmaceutical Services Negotiating Committee, the Optometric Fees Negotiating Committee and the National Community Hearing Association

Summary of our position

The primary care organisations above welcome this opportunity to submit brief evidence to the Committee on Integrated Care Systems (ICS). These ICS will undoubtedly have a critical role to play in the provision of healthcare in the future. In this submission we focus on just a few of the themes raised by the Committee, in particular around keeping quality and safety of care at the heart of the ICB priorities and maintaining a focus on prevention.

Primary care delivers the vast majority of NHS care to the population, and it is crucial to bring the real-world experience of front-line primary health professionals into shaping genuine integration at strategic level in all Integrated Care Systems.

At the heart of the Health and Care Committee's call for evidence are the core questions

- how will ICBs be different from the NHS and care structures which have gone before
- how will they better serve individuals and populations.

To our mind the key to meeting both challenges lies in Integrated Care Boards (ICBs) engaging all parts of the health and care systems in planning and working together at the strategic as well as local levels and especially through Integrated Care Partnerships (ICPs).

To date, a key weakness in the design of the new health systems has been the failure to provide for the structural engagement of primary care in the new ICBs and ICPs.

Just as with NHS Trusts and social care, the inclusion of the primary care professions in strategic advice, planning, and decision-making is too important to be left to arbitrary local decision. It is – in our view – the key to developing genuinely integrated services which focus on prevention and early intervention, shaping services around the needs and wishes of individual patients and populations, and maximising the efficiency and effectiveness of whole systems.

To put this matter beyond doubt, we want Integrated Care Boards to be required to work with primary care services when preparing and revising their five-year plans, in the same way they are required to work with NHS trusts and NHS foundation trusts. And we would like a mandated presence for primary care professionals on Integrated Care Partnerships.

Throughout the passage of the Health and Care Bill through Parliament we called for both of these things, and we welcomed support for them from former Health Ministers, NHS leaders and Parliamentarians.

Although the consultation and mandatory presence have not been enshrined in the Health and Care Act, we welcomed reassurances given by Lord Kamall that "partnerships will need to involve … representatives from across the system, including professionals from primary medical, dental, pharmaceutical and optical backgrounds", that the Government "supports the idea that primary care should be integral to ICB planning" and that they are "open to further conversations" on this.

We are keen to work with Ministers and officials on this, to ensure that the real-world experience of front-line primary health professionals is harnessed within ICS in the interests of patients and the NHS. This may well be in the form of improved guidance on this matter to ICBs and ICPs, and we would very much welcome the Committee's support for this.

Conclusion

Healthcare in England is an isosceles triangle with primary care at its base supporting, shaping and driving spending decisions within the superstructure. Unfortunately, the focus of policy-makers is often on secondary care, where the big spending is. However, it is unwise not to heed or to give only a minor voice to primary care (on which so much else depends), in any strategic and planning system.

We hope that the approach as outlined by Dr Claire Fuller in her recent stocktake review is implemented so that primary care can influence service development and transformation as of right and play our full roles in meeting the needs of our changing population, as we stand ready to do. But we need national leadership to remove obstacles and enable us to shape what is right for patients and the NHS.

Recommendation

We would like to see systems guidance requiring Integrated Care Boards to demonstrate how they have worked with primary care services (in the widest sense) when preparing and revising their five-year plans, and asking Integrated Care Partnerships to have a mandated presence for the primary care professionals.

Background Information

Fuller Stocktake

The stocktake led by Dr Claire Fuller was part of the "further conversations" (as noted by Lord Kamall), which we positively engaged with and whose findings we strongly support.

As Dr Fuller recognised, ICSs have four main aims: improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and helping the NHS support broader social and economic development. Within this, she recognised the wider role for primary care providers in prevention and meeting health and wellbeing needs and concluded that there had been "too much onus on GPs for being gatekeepers for the system".

To date there has been no implementation plan or clarity about how these recommendations will be turned into action at ICB level, but we believe it is essential that they are.

Primary Care Support for Reform

Primary care fully supports integrated health and social care, the focus on prevention and early intervention, and shaping services around the needs and wishes of individual patients and populations – this is how primary care already operates. We agree with Dr Claire Fuller's comments that 'we need to move away from thinking about healthcare in organisational siloed terms'. We need to focus much more on the continuity of care that patients receive.

Primary care providers already focus on prevention and early intervention and shaping services around the needs and wishes of individual patients and populations. The NHS has a major opportunity now to build on this firm foundation, an opportunity it is in danger of missing.

At the heart of this are core primary care services designed at a national level and delivered locally. We strongly welcomed confirmation by DHSC and NHS England that they would retain national contracts and negotiating mechanisms for core primary care services. This is crucial as spending on primary care is already dwarfed by hospital spending and must be protected. Indeed, it must grow in order to increase capacity to meet growing healthcare needs and to deliver more personalised care, closer to home. This is crucial in achieving the NHS Long Term Plan goals to transform outpatient care and deliver more care and support out of hospital and close to home. But is unlikely to happen without primary care, in its widest sense, being round the crucial strategic, advisory table with a real voice at ICP level – primary care must not be an after-thought.

Existing NHS primary care providers should be the 'go to' providers for expanding NHS capacity outside hospital, making use of pre-existing skills and facilities, building on and expanding the existing primary care estate and minimising the transaction costs of setting up new services. This ultimately provides the capital, facilities and equipment the NHS could not afford alone. The new NHS Provider Selection Regime should actively facilitate this and be designed to avoid the commissioning mistakes of the past.

Primary Care Voice and influence

For all these reasons, it is vital that clinical representation and engagement from across primary care is embedded at strategic advisory level in each ICS's Integrated Care Partnership. ICBs should be strongly encouraged always to seek specialist input from the broader primary care family, as this will benefit patients, the NHS and taxpayers in the short and long term. These realities were recognised in the NHS Long Term Plan but are not guaranteed in the Health and Care Act. The NHS Long Term Plan should be taken seriously and a greater voice for primary care built in.

Without engagement at strategic partnership level, we are concerned that genuine change and service transformation will not happen - either aims will be unrealistic (uninformed by primary care realities) or insufficiently transformative (overlooking primary care-based opportunities).

ICBs and Integrated Care Partnerships already have the backlog and the lasting effects of the pandemic to deal with and, without primary care engagement as equal partners at the table as of right, recovery may be seriously impeded, opportunities missed, and serious transformation will not happen.

We will monitor this situation closely and continue to make this case to Government, including reviewing examples of where this is already happening naturally, for example Cheshire and Merseyside ICS, where community pharmacy has secured a seat on the ICB and Greater Manchester ICS, where a primary care provider Board has been set up to provide input to the primary care representative on the ICB.

Local Primary Care Committees

Local Representative Committees (Local Medical, Dental, Pharmaceutical and Optical Committees) have been an important part of the NHS since its foundation as the effective voices of primary care and sources of professional clinical leadership at strategic level. Their vital role as the statutory voice of primary care contractors should be recognised through mandated roles within ICPs, including as

consultees to annual forward plans and any decisions affecting primary care services, to connect local grassroots clinicians and proximity to patients with strategic planning and advice.

To ensure parity of voice and support with Trust, NHS commissioning and social care staff, GP, dentistry, pharmacy and primary eye and hearing care roles on ICPs should be remunerated, otherwise they will not be able to attend crucial meetings and will not be in the room when key advice is given to commissioners.

Primary Care Workforce

Workforce pressures are now very serious across the health system, including in primary care and we welcome the general commitment of the NHS to more effective workforce planning, but this needs to be based on the changing shape of the workforce in the 21st century (as a minimum using whole time equivalents in addition to headcount) and more attention needs to be given to retention and vocational training to secure sufficient primary care clinicians for the future.

The NHS and social care must have the workforce required to meet the needs of the population, now and in the future, and some ICB geographies will be too small to plan effectively. We believe there should be a responsibility for NHS England to produce ongoing, accurate and transparent workforce assessments to directly inform recruitment needs, as well as responsibility for delivering these staff. We welcome the recent report by this Committee into the NHS workforce.

About our organisations

PSNC represents the owners of all 11,200 NHS community (high-street) pharmacies in England. We negotiate with the Department of Health and Social Care (DHSC) and with NHS England and NHS Improvement (NHSE&I) on behalf of those pharmacy owners. Our goal is to develop the NHS community pharmacy service, to enable community pharmacies to offer an increased range of high quality and fully funded services that meet the needs of their local communities and provide value and good health outcomes for the NHS and the public. For more information, please visit https://psnc.org.uk/

The Optometric Fees Negotiating Committee (OFNC) is the national negotiating body for eye care in England with the Westminster Parliament, the Department of Health and Social Care and NHS England. It comprises the leaders of the UK representative bodies: ABDO, AOP, FODO and BMA (for OMPs) and works in partnerships with the College of Optometrists and the General Optical Council. For more information, please contact the Chair, Gordon Ilett (gordonilett@gmail.com) or the Secretary, David Hewlett (david.hewlett@fodo.com)

The National Community Hearing Association (NCHA) is the professional representative body for community hearing care providers in the UK. We exist to improve hearing care for all and work with the NHS, health and social care bodies and policymakers to make this happen. For more information, please visit https://www.the-ncha.com/