Future Integrated Care Systems: Getting Primary and Community Care Reform Right

Report of the Health Devolution Commission Roundtable held online on 28th March 2024

CONTENTS

1. INTRODUCTION

This is a detailed report of the key issues and ideas on reform of primary and community care discussed at the online meeting of the Health Devolution Commission on 28th March 2024. The roundtable was co-chaired by the Rt Hon Sir Norman Lamb and the new co-chair of the Commission, Dr Nik Johnson, Mayor of Cambridgeshire and Peterborough, who is the health lead for the ten Metro Mayors in England (the M10). The roundtable included presentations by two panels of speakers each followed by questions and discussion:

Expert policymakers' panel:

- Baroness Pitkeathley, Chair, Lords' Integration of Primary and Community Care Committee
- Ruth Rankine, Director of Primary Care Network, NHS Confederation
- Beccy Baird, lead author, Making care closer to home a reality, King's Fund

Expert practitioners' panel:

- Dr Jane Harvey, Clinical Director, Healthy Hyde, Greater Manchester. Slides here
- Laura Churchill, Director of Strategy, Partnerships and Integration, Central London Community Healthcare NHS Trust and former Director, London ICS Network. Slides here
- Dr Ashish Dwivedi, Director, Health Integration Partners. Slides here

The 38 attendees included Commissioners, guest speakers and observers. Apologies were received from the co-chair Imelda Redmond CBE. Although remaining as a Commissioner, the Rt Hon Andy Burnham is stepping down as a Co-chair to be replaced by Dr Nik Johnson. A recording of the meeting is available here.

Briefing paper: A comprehensive briefing paper prepared for the roundtable is available to read here. Since the Commission's last meeting in January there have, in addition to the reports summarised in this paper, been further reports and analysis published of particular relevance to the Commission including:

- Unlocking reform and financial sustainability by the NHS Confederation, March 2024
- 'Waiting times for adult social care', report by the Health Service Journal, March 2024
- 'Public attitudes to the NHS and social care', by the National Centre for Social research, March 2024
- 'Integrated Care Systems and the health needs of babies, children and young people', by the Children and Young people's Health Influencing group, January 2024

2. PRIMARY AND COMMUNITY CARE POLICY

2.1 House of Lords Inquiry

Baroness Jill Pitkeathley, Chair of the House of Lords Integration of Primary and Community Care Committee spoke about the findings of their report 'Patients at the centre: integrating primary and community care' published in December 2023 and highlighted the need for action to address four key obstacles to change and the report's 16 recommendations concerning:

- Structures and organisation
- Contracts and funding
- Data sharing
- Workforce and training

A debate on the report and the Government's response will take place in the Lords on Thursday 9th May, 2024.

2.2 NHS Confederation Analysis

Ruth Rankine, Director of the Primary Care Network at the NHS Confederation reminded the Commission that primary Care includes General Practice, Pharmacy, Optometry and Dentistry; and that in many areas of the country these service providers were leaders in developing and implementing new ways of collaborative working and innovative practice with patients.

However, change by local inspirational leaders was taking place against a national backdrop of low morale and high pressures on resources with the focus on secondary care, and primary/community care being overlooked. In many areas there was a lack of capacity for system leadership and improvement as the primary care system requires people to take on leadership roles alongside their day job of clinical care for patients.

The future of primary care needs move 'beyond surviving into thriving' with a different mind-set. It requires a collaborative delivery level at every level from the ICS through to the hyper-local; greater continuity of care whilst improving access; maximising the skills of the whole workforce; new models of care; primary care collaboratives at a scale to match those of other health providers; and additional investment in strong leadership to give leaders time to be strategic and sit alongside the leaders in the rest of the system. .

90% of NHS activity occurs within primary and community care but it receives only 6% of the NHS budget. And this proportion has nearly halved from the 10% it used to be. This imbalance has to change with a greater proportion of new resources shifting from secondary to primary and community care - from institutional care to the care in the community. This will require investment in infrastructure and capacity, new contracts and local flexibility and autonomy to design services to meet local needs and demographics.

The current funding and delivery model can be a barrier to a more person-centred, pathway and place-based approach that provides greater opportunities and incentives for collaboration.

2.3 King's Fund Research

Beccy Baird, researcher for the King's Fund, described how NHS resources were flowing in the wrong direction because of a fixation on short-term savings and because care closer to home was not necessarily cheaper and won't release significant savings in the short term. However, she also pointed out that if, in future, proportionally more money was **not** spent on primary and community care services, then **even more** money would have to be spent on acute services.

Primary and community care services suffered from their lack of visibility with data harder to collect and use to aid decision making compared to hospital data. Public attitudes to the NHS can also be a barrier with campaigns to keep hospital services open attracting a lot of support. However, public concern about poor access to a GP or a dentist is now very high and becoming more politically salient.

For NHS leaders it can be easier to 'extract cash' from primary and community services by reducing them or closing them down when this is much harder to do practically in hospital that are building-based. Extracting hospital staff to work in the community alongside colleagues in primary and community care maybe a better approach to shifting resources than trying to extract cash.

Single-condition care pathways across primary and secondary care have advantages for some patients but could also act to accelerate resources in the wrong direction. Moreover, as most people have co-morbidities that require a person-centred approach to get well, they may not be the best clinical approach to meeting patient health needs. Meanwhile a focus on hospital elective care by national health leaders can be a distraction from a focus on primary and community care, and this is reinforced by the financial incentives currently in place.

Some suggestions for action to address these concerns include:

- Putting **a spotlight** on primary and community care at every level in the system
- ICBs undertaking **performance management** of their primary and community care systems Ensuring that **local workforce plans** reflect primary and community care services as a priority
- Investing a greater proportion of any **growth money** in primary and community care
- Greater **devolution of resources and decision-making** to frontline structures/organisations
- Equipping the leadership and capacity of the primary and community care system at every level to act strategically

3. PRIMARY AND COMMUNITY CARE PRACTICE MODELS

3.1 Healthy Hyde, Greater Manchester

Dr Jane Harvey, Clinical Director for Healthy Hyde in Greater Manchester gave a rich presentation - **here** - outlining their collaborative model of care. Some of the key points she made included:

- The General Practice registered list of patients in the population is a central concept within the care model that is personal, powerful and precious
- Investment in the NHS estate came from the local partners (not the ICB)
- The Healthy Hyde primary care network operates more like a 'start-up' business with many risks, exposure to external events and pressures, and challenges to the existing formal structures and income streams in primary care
- One core problem now is that the Healthy Hyde care model is not being embedded into the mainstream practice of the ICB
- It seems to be hard to get people with coalface/boilerplate experience in a place to influence decisions and achieve the goal of putting patients at the heart of the hardwiring of the system

3.2 Central London Community Health Care:

Laura Churchill, Director of Strategy, Partnerships and Integration at the CLCHC Trust presented slides - here describing primary and community care services as being at the cutting edge of change. Their community trust model meant they were able to operate a person-centred, place-based collaborative way of working at different levels - hyper-local, borough and cross-borough - through a community provider collaborative.

The Community Trust was, in effect, a community anchor institution able to have a wider positive impact on the local economy and local communities. Laura described the roles that the community trust model can undertake at different system levels

Strategic:

- A key strategic partner within the ICP to design system strategy
- Development of strategic partnerships at scale and locally
- Population Health Approach

Tactical:

- Consideration for the operating model and how it is executed
- Organisational form and simplifying the provider landscape
- Leveraging our infrastructure

Operational:

- Supporting coherence between integrated neighbourhood teams in terms of operations and outcomes
- Supporting the workforce for long term viability and anchor status within Place
- Leveraging relationships across Local Government and other community partners

3.3 Health Integration Partners

Dr Ashish Dwivedi, Director of Health Integration Partners presented a summary of a detailed presentation - **here** - describing the negative impact of a primary and care system that works inefficiently on an individual patient and the system as a whole; the opportunity this presents for local systems to have a positive impact on both people's lives and the costs savings for services they receive; and what this means in terms of reducing costs in the system.

Drawing on his detailed analysis of the costs and savings involved, Dr Dwivedi highlighted a number of key observations and conclusions:

- 70% of the frail population is mild frail giving a big opportunity to mitigate growth in demand in future and improve outcomes
- Over 50% of all services (except A&E) were used by those who are frail.
- Over half of that use is by 6% of the population (severe/moderately frail).
- The rhetoric of support for providing care in the community is not matched by the reality of a 6% decline in the number of permanent qualified GPs, and a 21% increase in hospital doctors than 5 years ago
- 20-30% of hospital admissions are avoidable. And in February 2023 there were 13,000-15,000 people remaining in hospital beds each day with no clinical reason to stay in hospital having a direct impact on health from their resultant deconditioning. The system is in effect passively creating a second pandemic of unaffordable demand on a system that in many places is already bursting at the seams and in a serious funding deficit.
- An existing proven model of primary and community care can deliver a 54% reduction in non-elective admissions, a 25% reduction in GP appointments, and improvements in both patient and staff experience

Going forward, he identified the need to depoliticise the NHS so the direction of change is sustained between parliaments; to **demedicalise** the NHS to work in partnerships with local government and others on the social determinants of ill-health; and to **go beyond the rhetoric of collaboration** and create the right combination of policy, power and permission to make change happen.

He also identified three essential elements of system change that were needed now:

Devolve: Create agile adaptive systems with shared accountability of funds

- Devolve joint health and social care budget to local level (Place and locality) in stages
- Create power, leadership and accountability at locality level with inclusion from people
- Enable agency and accountability at the right level (when everyone is responsible, none is responsible)

Define: Define the locality ecosystem

- Real clarity on what it means at a practical level including how and why would partners within a locality work differently.
- Set expectations and commitments
- Understand your resources and how they could be utilised best

Deliver: One step at a time – it is a ten-year commitment

- Clear roadmap for delivery – a number of strands
- Staged delivery with learnings from establishing localities
- Embed a learning and development culture, with quality improvement cycles.

4. KEY ISSUES AND RECOMMENDATIONS

As can be seen from the above, the roundtable was wide-ranging in scope and in-depth on the nature of best practice. However, eight common issues with accompanying recommendations were identified in order to get primary and community care right:

4.1 Integrated Care Boards

ICBs should put a spotlight on primary care (in its broadest sense) in their board meetings, invest resources in their leadership and capacity to act strategically, and develop a more mature commissioning and contracting model that supports local collaboration, innovation, diversity, and community engagement for achieving health and wellbeing outcomes.

Examples of best practice should be identified and then embedded and hardwired into local systems though appropriate funding incentives and rewards, workforce training and development, and capacity building for leadership and change.

4.2 Shifting resources into the community

Positive leadership and capacity within ICBs is required to ensure there is a visible shift in NHS resources from institutional-based hospital care to community-based primary and community care services. This should be underpinned by a reduction in national targets for hospital care and new financial incentives to support growth in primary and community care services. The shift should not be just a shift in any 'growth money' but should include shifting the allocation of existing resources. Moving clinical staff out of hospital to work with colleagues in community-based services may be one approach to shifting existing resources away from institutionalised care and help to build stronger links between the two sectors.

It would be helpful for NHS England – working with the LGA, NHS Confederation and other partners - to bring together comparable examples of where local systems have achieved success in making a shift in NHS resources away from institutional to community-based care; and where this has also helped to reduce demand and costs on the hospital system.

4.3 Clinical and non-clinical working together

The term 'primary and community care service' is still applied solely to the narrow clinical lens of the NHS definitions of primary care and NHS funded community care services. This is silo thinking and a major barrier to the integration of services.

Primary Care Networks must be widened in scope to include social care and public health activities commissioned by local councils and delivered by a wide range of public, voluntary and private sector providers.

4.4 Devolution and diversity

Devolution of power, resources, and leadership capacity (NHS and social care) to a locality level is an essential mechanism to achieve the change required. This should be accompanied with a clear definition of the local 'health and care ecosystem' to be improved, and a depoliticised, de-medicalised 10-year strategy for delivering the change required.

Local flexibility, diversity and innovation should be the norm not the exception in the way that hyper-local integrated care systems develop and operate (not a single top-down model) built on learning from the many different integrated care models already in existence and developed in partnership with local people and community organisations.

4.5 Community anchor institutions

Person-centred, place-based collaborative primary care providers working with local government, the VCFSE sector and other public and private sector organisations should be seen as much an anchor institution for local social, economic and community development as building-based institutions such as hospitals, or educational establishments.

4.6 Care pathways

The limits and system impacts of single condition-based care pathways on patients and resources should be recognised.

Over time they should be replaced with multiple-morbidity, people-centred, place-based care pathways that aim to improve people's health and wellbeing through care services in the community rather than hospital-based care services.

4.7 Priority population groups within primary and community care

People who experience health inequalities in accessing services or in their health and wellbeing outcomes and for which new ways of working are required include includes people with learning disabilities and autism, children living in poverty and low-income areas, people from different ethnic groups, people who are homeless, people with mental health problems and older people with frailty. Not every person requires the same kind of service, and different groups such as older people with frailty and working age adults with a learning disability need different approaches.

The health inequalities experienced by particular groups in different localities must be understood and form the basis for setting priorities and new ways of delivering primary and community care services.

4.8 Public attitudes and perceptions

Achieving the shift in resources and focus onto primary and community care will be helped greatly by addressing public attitudes towards hospitals and community care services.

This is a task that the NHS should take seriously and be supported by local and national politicians who can show their support for the NHS by visibly supporting and identifying with non-hospital forms of the health service in action.

Phil Hope and Steve Barwick, the Health Devolution Commission Secretariat, April 2024

The partners of the Health Devolution Commission are NHS Confederation, Local Government Association, London Councils, West Yorrkshire Helth and Care Partnership, Mencap and Barnardo's.