NHS Confederation

Integration of Primary and Community Care

April 2023

About us
The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high quality-care, and reducing health inequalities.

This evidence has been collated by the NHS Confederation's Primary Care and Community Networks with input provided by our Integrated Care Systems Network. The Community Network is a joint network hosted by the NHS Confederation and NHS Providers. The Network will make a separate submission focusing specifically on the community sector. As the Committee will be aware, Fiona Claridge, Assistant Director of London and East gave oral evidence on Monday 20th March 2023.

Summary
The NHS Confederation is pleased to see that this Committee has been established to look at this important issue – with community health services and primary care traditionally not getting the same political focus and funding priority as acute services.

Primary and community care services provide vital support to millions of patients every day but, like much of the NHS, are now under considerable strain. While there is an intention and ambition to integrate primary and community services, the current commissioning and contacting arrangements do not support it with policy continuing to be developed in silos from the centre at both NHS England and the Department for Health and Social Care.

With the Health and Care Act formalising integration and the Covid pandemic highlighting successful collaboration across the whole health system, there are opportunities to shift towards a greater focus on population health, with services in place across systems that wrap care around the person or place. These structural changes needed to be accompanied by a cultural shift and governance changes to ensure their potential benefits are realised.

Challenges and barriers to integration
What are the main challenges facing primary and community health services?

1. Community health services play an essential role in helping people stay healthy and supporting them to live as independently as possible at home. Although there has

been a long-standing policy ambition to deliver more services out of hospital[1], realising this has been a challenge for successive governments.

2. Given the backdrop of pressure across all health and care services[2], including ambulance delays and increased demand for A&E services, there is a risk that political and service leaders will focus and prioritise acute provider performance. Key national measures and targets for the health and care system need to shift towards longer-term goals to integrate care and ensure services can focus on population health, rather than being focused on short-term acute measures.

3. Primary care is in the midst of an access crisis with need for services far outstripping capacity and the workforce overstretched. In spite of this and a decline in the number of full-time GPs, primacy care delivered 335.7 million appointments in 2022, surpassing the number of pre-pandemic appointments for the first time.[3]

4. While the primary care workforce has rallied to deliver this increase in appointments, alongside driving the rollout of the coronavirus vaccine, current support and funding for primary care are being increasingly tied to the measures for access, rather than the causes of the crisis, including workforce, estates and prevention.[4]

5. The community sector has significant workforce challenges [5]. The sector has its own backlog of care, which has received no additional funding and is lacking a targeted recovery strategy thus making it difficult for providers to address backlogs of care. The comparative lack of centrally collected data from community services has been a key component in this lack of specific focus from the centre.

6. The NHS is focused on measuring targets set, which tend to be focused on the delivery of services – rather than patient outcomes. Currently there is a tendency to view primary and community care as supporting other parts of the system – often measuring them in relation to admission avoidance or discharge from hospital rather than how they have supported a patient to stay well at home for longer.

7. Current funding and contracts also focus on achievements against key operational targets as measures of impact.

8. To reverse this trend, better data collection and publication about services provided in the community, by both primary and community providers, including their workforce, and budgets will be essential to empower NHS leaders to prioritise how resources are allocated to meet the needs of local populations.

What are the key barriers preventing integration, and how might these be overcome?

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[1] https://www.longtermplan.nhs.uk/online-version/chapter-1-a-new-service-model-for-the-21st-century/1-we-will-boost-out-of-hospital-care-and-finally-dissolve-the-historic-divide-between-primary-and-community-health-services/
[2] https://www.nuffieldtrust.org.uk/qualitywatch/nhs-performance-summary
[3] https://www.instituteforgovernment.org.uk/performance-tracker-2022-23/general-practice
[4] https://www.nhsconfed.org/publications/gp-contract-changes-202324-what-you-need-know#:~:text=On%206%20March%202023%2C%20NHS%20England%20published%20an,access%20performance-based%20funding%20%28IIF%20and%20QOF%29%20workforce%20flexibilities
[5] https://www.nhsconfed.org/publications/there-no-community-without-people

9. The NHS has faced significant restructuring since 2019 with legacy relationships and culture that are still adapting. This includes a culture of competition, embedded by the 2012 reforms, which has further impacted the pace and scale of integration within the wider system.

10. Members outlined that competing priorities and misalignment between primary and community care can cause difficulties when building relationships and integrated teams.

11. Integrated teams require a high level of trust and cooperation and this has been hampered by existing contracting structures and competitive recruitment practices over integrated roles, such as the ARRS Mental Health Practitioner - recruited in a joint venture by Primary Care Networks (PCNs) and Mental Health Trusts. By autumn of financial year 2022/3 at least 62% of PCNs had recruited at least one mental health practitioner.[6]

12. That said, this does in turn have an impact on the wider mental health workforce where there is also workforce shortages, as these practitioners are by and large recruited from Mental Health trusts.

13. Relationships between Integrated Care Boards (ICBs) and the community and primary care providers they support are essential to support integration and in some areas, community and primary care providers will be board members themselves. However, the success of these relationships varies significantly, with some members reporting resistant relationships leading to a drop in collaboration and difficulty commissioning services. Without a shared vision, each part of the system is at risk of embedding a culture of siloed working.

14. Across primary and community care there is a wide and varied workforce, often working alone or in small teams in the community and in people's homes. The workforce needs to feel valued and recognised for the significant contribution they make to the health and care of the population.

15. Our members agreed that a whole system focus on prevention, health improvement and delivering care 'close to home', provides a shared purpose and remit for local services to work together and drive integration.

16. Siloed working has been enhanced by difficulties in communication across the system and a lack of funding for IT interoperability, preventing progress in sharing patient data and wider integration.

17. Where shared patient records do exist, they are often restrictive with providers only able to see information about the patient linked to their part of the system, rather than the patient's care and health as a whole.

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[6] https://www.england.nhs.uk/mental-health/working-in-mental-health/mental-health-practitioners/

18. System level support for IT integration has been cited as a priority for providers looking to deliver joined up patient care at neighbourhood level. In order to form connected patient pathways, place and system level consistency is a vital first step.

19. Estates have also made integration challenging, with limited ability to increase and enhance estates to facilitate multi-disciplinary team working.

20. In Tees Valley, hospital and community providers have a strong relationship with the local GP Federation (a group of GP practices working together), and collaborate on the virtual frailty ward, run by the Federation. Building on this positive collaboration, the Federation is now working with the ambulance service to keep patients in the community. This provides primary care staff and patients with access to an integrated single point of access – 24 hours/ 7 days a week.

21. In mental health, the community mental health transformation programme aims to integrate primary care and community mental health services to streamline pathways for people using these services. Several pilot sites have produced important initiatives and programmes that are improving outcomes in their areas and transforming mental health care for the local population.[7]

What are the implications of the government's long-term workforce plan for the NHS on primary and community care staffing?

22. We welcome the development of community-based multi-disciplinary teams where health and care professionals come together to plan and coordinate people's care.

23. There are currently over 132,000 reported vacancies in the NHS[8], with primary care having a shortage of 4200 GPs and a high turnover of ARRS staff due to pressure and uncertainty over future funding for roles.[9]

24. The Royal College of General Practitioners (RCGP) has estimated that up to 19,000 could leave the profession in the next five years, with more GPs are currently leaving the profession than joining.

25. Primary and community care leaders have highlighted that their organisations currently recruit integrated roles from the same small pool and unintentionally undercut the other's staffing in order to fill their own roles. A comprehensive workforce plan for greater staff sharing and increasing the available pool of staff would have far reaching benefits.

26. The government's long-term plan has the potential to ensure we are training the workforce needed for the future by tracking population need. Given our ageing population, we will need to ensure that in addition to training more people to work across the NHS, a bigger proportion will need to be working out of hospital.

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[7] Sheffield primary care mental health transformation | NHS Confederation

[8] https://lordslibrary.parliament.uk/staff-shortages-in-the-nhs-and-social-care-sectors/#:~:text=1.1%20NHS%20workforce,-The%20latest%20NHS&text=Despite%20these%20increases%2C%20however%2C%20the,a%20vacancy%20rate%20of%209.7%25.

[9] https://www.nhsconfed.org/publications/there-no-community-without-people#:~:text=Now%2C%20despite%20growing%20demand%20for%20services%20and%20strategic,shortage%20of%204%2C200%20full-time%20equivalent%20GPs%20in%20England.

27. It is critical that the government's long-term workforce plan is published without delay and that it is fully-funded.

Governance and system structure

What is the impact of recent structural changes to the NHS in England on integration between primary and community care services?

28. The Health and Care Act 2022 has formalised voluntary arrangements that were already taking place within the system. The NHS Confederation have called for a 10-year moratorium on further top-down restructures[10] due to system support for Integrated Care Systems (ICS). The NHS needs structural stability to deliver long-term changes, including improvements in health outcomes and inequalities – areas in which primary and community care play a vital role.

29. We believe the recent legislative changes were important but are only a starting point. If ICS are to do things truly differently, they must have autonomy to focus on accountability to local communities and to system partners as well as the centre. System leaders should be empowered with the autonomy to deliver long-term change alongside teams delivering care and driving integration.

30. The appetite for integration exists within the system and increasingly there is a greater focus on population health and how services can work together around the person and place. For example, PCNs were established with the key aim of dissolving the divide between primary and community care and this has gone well across the country when mandated in the contracts[11].

31. Since the establishment of PCNs, external pressures have determined the bulk of their activity. However, initiatives including Enhanced Health in care homes which bring together community and PCN services, have demonstrated that the right level of instruction and dedicated funding can safeguard outcomes by incentivising both parts of the system to prioritise integrated working.[12]

32. However, progress is currently varied across England, with some areas moving towards advanced and mature partnerships. For example, in Kensington and Chelsea – My Care, My Way[13], a joint case management service between primary and community services, includes voluntary and community sector organisations (VCS).

33. Community teams are increasingly aligning with PCN boundaries and forming the foundations for Integrated Neighbourhood Teams, but our members recognise that mature leadership at place is essential to providing the support and infrastructure which will ensure the success of Integrated Neighbourhood Teams.[14]

Is the current primary care model fit for purpose and servicing the needs of patients?

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[10] https://www.nhsconfed.org/publications/renewed-vision-nhs
[11] Primary care networks: three years on | NHS Confederation
[12] https://www.england.nhs.uk/community-health-services/ehch/
[13] https://mycaremyway.co.uk/
[14] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

34. The current model of primary care is patient focussed and driven by the intention to provide high quality, cohesive care in the community.

35. General practice, dentistry, community pharmacy, optometry, and audiology are becoming more closely connected than before and have been developing increasingly innovative ways to meet growing patient need.

36. PCNs alone have taken on around 20,000 additional specialist staff through the ARRS in order to increase the number and variety of appointments available through general practice.

37. Patients are currently able to access first contact staff from GPs, to physiotherapists, paramedics, and mental health practitioners. Moreover, the increase in social prescribing and health coaching available in practice is supporting patients who are being negatively impacted by the wider determinants of health.
38. Primary care is now delivering a more holistic service than ever before, in more flexible ways than ever before. In 2022 general practice delivered 115.6 million virtual and phone consultations, alongside 220.1 million face-to-face appointments[15], allowing patients to access care in the way which best met their needs.

39. While patients are still experiencing barriers to access and regional variation in service, these issues are within the system's gift to improve with targeted support to PCNs which are already working to identify improvements.

40. The view of our primary care members is that the key to addressing access issues is through the continued delivery of primary care at scale, and for national policy-making – including how governance is undertaken – to support and incentive this.

How successful have Primary Care Networks (PCNs) been in facilitating joined up working between primary and community care provision, and other parts of the system?

41. PCNs are the building blocks of ICSs and are instrumental in connecting out of hospital care including ambulance, VSCE, local authorities and community trusts.

42. Since the establishment of PCNs there has been an increase in services co-delivered between system partners, including integrated roles like ARRS paramedics and virtual wards hosted by PCNs and GP Federations to provide care to patients in their community.

43. Where these services have been most successful, they are supported by strong place-based leadership, flexible contracting, good cross system relationships which have been invested in by both partners, and willingness to codesign and share resources.

44. Key enablers for integration include infrastructure, leadership capability, and capacity, all of which can be supported centrally by ICS to further support the current efforts being led by primary care.

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[15] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/february-2023

45. Neighbourhood working teams have been established in Leeds across health, wellbeing, older adults, children's services, neighbourhood improvement and community cohesion. A strategic review of the community working approach in Leeds was undertaken, identifying that a new neighbourhood model is needed which more explicitly values and enables community organisations. It also recognised the importance of neighbourhoods as the hub for service integration enabling preventative and proactive, outcomes-based care at home and which reduces acute admissions. Central to this is continuing to evolve Local Care Partnerships with Primary Care Networks at their centre.[16]

To what extent have Integrated Care Systems (ICS) been able to deliver the aims they were set up to achieve?

46. Many Integrated Care Systems (ICS) have existed in shadow form since 2016 with some much further in their evolution and relationships between community and primary care and wider integration with the system.

47. Assessment of system performance in ICS should consider longer term measures such as improvements in health outcomes and inequalities. In setting targets and objectives, the centre should focus on 'why' and 'what' systems should achieve, not the operational details of 'how' and assess ICS on outcomes related to ICS four core purposes.

48. ICS have been created to bring primary and community care leaders together with other providers to better integrate services and improve health outcomes, patients' experience and improve productivity. Integrated care boards and their structures therefore include primary and community care leaders.

49. Community and primary care providers understand the needs of local populations and so know how best to allocate resource at a system level. However, in some cases ICBs are not yet prioritising services delivered in the community.

50. The National Audit Office (NAO) [17] has warned of a risk that immediate NHS pressures crowd out some of ICS key aims and purposes like tackling health inequalities. Given the need to meet performance targets (particularly reducing waiting times and the elective care backlog) and balance budgets in the short term - this risks undermining the transformation ICS need to deliver to improve patient care and make the health and care system sustainable in the long term. Primary and community care are the vehicles for the bulk of this transformation.

Innovation

In what ways could existing infrastructure be enhanced to improve the use of health technologies, and what are the benefits for patients?

51. With new models of care emerging and evolving, there is a need for increased data sharing and integration between care settings, organisations and geographies.

[16] https://www.leedscommunityhealthcare.nhs.uk/our-services-a-z/neighbourhood-teams/
[17] https://www.nao.org.uk/reports/introducing-integrated-care-systems-joining-up-local-services-to-improve-health-outcomes/

52. Members noted that data integration presents an opportunity to better join up care and improve outcomes for patients, harnessing the benefits of health technologies including remote monitoring. Members noted automation and digitisation are key areas for improvement, and that there is a need for culture, headspace, leadership and training to embed long term changes to optimise patient outcomes and quality of care.

53. Moving forwards the NHS needs to ensure that aspects of the services become digitised, with staff trained to think digitally.

Could you please outline one key change or recommendation to enable effective and efficient integration in the delivery of primary and community care services?

54. While we welcome the establishment of this Committee and the focus on primary and community care, for integration to work we need to look at the whole health and care system in its entirety. Moreover, it is vital to recognise the history and impact of competition and the extraordinary events of the last few years which have impacted the first formal tranche of integration which saw PCNs established in 2019.

55. The second tranche, spearheaded by ICS, will require collaboration and flexibility at the local level to build on the ongoing culture change and allow local leaders to deliver services which meet local needs.

56. It is important to note that the community sector is split between stand-alone community health trusts, community interest companies who deliver community health services for the NHS and integrated trusts who deliver community health services alongside other services.

57. Integrated trusts largely deliver acute and community services so to look at primary and community services in isolation from acute care fails to recognise the role these organisations play. We would urge the Committee to not simply look at one or numerous parts of the system in isolation – we need joined up thinking across the system.