The Baroness Pitkeathley OBE
Chair, Integration of Primary and Community Care Committee
House of Lords
London
SW1A 0PW

3 May 2023

Dear Baroness Pitkeathley,

Integration of primary and community care – Submission from the British Geriatrics Society

The British Geriatrics Society (BGS) is pleased to be contributing to this important inquiry looking at the integration of primary and community care. This submission has been developed by members of the BGS Community and Primary Care Group.

1. About BGS

1.1 The BGS is the membership organisation for all healthcare professionals engaged in the treatment and care of older people across the UK. Since 1947 our members have been at the forefront of transforming the quality of care available to older people. Our vision is for a society where all older people receive high-quality patient-centred care when and where they need it. We currently have over 4,600 members working across the multidisciplinary team, including geriatricians, nurses, GPs, allied health professionals and pharmacists and across acute, primary and community care settings.

1.2 The BGS Community and Primary Care Group (CPCG) was formed in June 2022 and was created out of the merger of two groups – the Community Geriatrics Special Interest Group and the GeriGPs Group (a group for GPs within our membership). The Community and Primary Care Group is chaired by two GPs and 865 BGS members are part of the group.

2. What are the main challenges facing primary and community health services? What are the solutions within the current framework? What steps should be taken to improve support for the long-term management of complex conditions in the community, and respond to the needs of patients and communities?

2.1 Primary care needs to be reconfigured to ensure that it better meets the needs of its largest patient group – older people. Currently members of the BGS CPCG report that there are too many targets and not all are useful for delivering high-quality care for their patients. Primary care needs to re-focus to ensure that non-urgent care is prioritised which will support people with long term conditions to live well in the community and reduce the chances of them requiring hospital admission.

2.2 GP services are currently split between two main areas – a) acute and urgent response; and b) management of chronic disease. During the pandemic, management of chronic disease was neglected, resulting in many people experiencing deterioration in their conditions and requiring more intensive hospital treatment. By ensuring that chronic illnesses can be managed in the community, some pressure on acute services will be relieved. However, there is not currently the capacity in primary care to adequately manage both chronic disease and acute on-the-day demand. Part of the solution to this could be to empower community pharmacies, with additional funding, to do more to manage aspects of chronic disease in the community, releasing pressure on general practice.

2.3 As is the case across the NHS and social care, there are not enough people working within primary and community care services to meet the demand for care from the population. Older people use the NHS more than any other population group and the vast majority of contacts with the NHS are within primary care. It is essential that the needs of older people living in the community are considered in workforce planning. With an ageing population, demand is set to increase, and the capacity to provide primary care must rise with it.

3. What are the key barriers preventing improved integration, and how might these be overcome? Could you provide examples of successful or innovative models of integration between primary and community care, either in the UK or internationally? How have they gone about achieving their aims of integration? How could these models be replicated and further developed to ensure consistency in the delivery of services across England? Could you give an indication of where integration has not worked well, and the reasons for this?

3.1 CPCG members report that for most of the country, integration is at an immature stage of development and point specifically to a lack of integration across health and social care. One of the biggest barriers to integration across services is the lack of IT infrastructure to support data sharing. Many areas have been slow to adopt digitalisation and hospitals and care homes often lack WiFi and other basic IT infrastructure. Many services still rely on paper forms which prevent data sharing and consequently is a barrier to personalised care planning. For many people accessing NHS and social care services, particularly adults with multimorbidity, care will be provided by a range of healthcare professionals across several organisations and settings. If data cannot be shared across organisations, care cannot be adequately coordinated.

3.2 Digitalisation within the NHS and social care faces cultural barriers and many areas will need incentivising to enact change. However, the use of digital infrastructure can improve patient care. For instance, capacity trackers providing live data feeds showing bed availability across the system can help people to be discharged from hospital more quickly. However, our members tell us that such systems are not used enough and consequently older people who could have been discharged remain stranded in hospitals.

3.3 BGS CPCG members highlight that when integration has been successful, it has been patient-centred. The integration of organisations for the sake of it is rarely successful and rarely results in a patient-centred service for older people. Organisations integrating need to have a common goal to guide their integration.

4. Pressures on primary care have been well documented. How would you assess the current state of community care, in particular the integration between both areas? What is the impact of developments in social care on other community health services?

4.1 Community care is regionally variable with considerable inequality between areas. Regions defined as 'hard to reach' face a considerable challenge in recruiting to vacant posts and this has a detrimental effect on the care provided. The community care workforce has been decimated. Much of the work carried out by these teams is responding to the need created by the acute system and those being discharged from hospital. The workforce available is not always fit to deliver high quality community care and is only able to deliver essential care. In this environment, integration is not considered a priority. Healthcare professionals working in the community are concentrating on keeping patients safe rather than on integration.

Even in areas where the workforce is in place, it is task-driven rather than case-driven and is not sufficiently patient-centred.

4.2 There has been a recent focus on the delivery of hospital-level care in a patient's home environment through services such as Hospital At Home, Virtual Wards or NHS@Home. These services provide opportunities for better integration across services. However, the workforce required to provide this care at home must come from somewhere and other parts of the system do not have the additional capacity to spare to ensure that these services are adequately staffed. For this reason, many services have been slow to start and are unable to develop the capability to deliver.

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

5.1 At the time of responding, the Government had not yet published its promised workforce plan. We are therefore unable to answer this question, though we note the ongoing delay in publication with disappointment.

6. What is the impact of recent structural changes to the NHS in England (enacted through the Health and Care Act 2022) on integration between primary and community care services? To what extent are the policy interventions aimed at integrating services delivering the results expected of them? What do these changes mean for patients in terms of access and satisfaction?

6.1 BGS members state that the impact of the Health and Social Care Act has been regionally variable. Some areas, particularly Manchester and Leeds where integration was already underway, have had positive experiences. Integration has been much more challenging in other parts of the country. Many areas have found that the project support needed to integrate services has been lacking and that partnerships are not mature enough to undergo the transformation required.

7. Is the current primary care model fit for purpose and serving the needs of patients? As it is currently configured, can the model of primary care deliver on the ambition of providing more care outside the hospital setting? To what extent does the current model enable working in partnership with other services? How does the current model secure parity for mental health provision?

7.1 The current model is understaffed and as such, cannot be considered fit for purpose for provision of additional unresourced care. In addition to this, there is a lack of understanding about general practice and primary care as a specialty. There needs to be a recognition of the concept of a generalist specialism and in particular, acknowledgement that primary care is a specialty in its own right.

7.2 Junior and inexperienced allied healthcare professionals tend to be over-represented in primary care which increases supervision demands on senior staff. While it is important that junior staff are able to access experience in primary care, the demand for supervision means that work that needs to be conducted by senior clinicians is often not prioritised and that patients often do not get the benefit of the expertise and experience of more senior staff. Many GPs, particularly those who are business-owning, do not feel that they can refuse to have junior staff placed within their practice.

7.3 In terms of the provision of mental health services, BGS members observe an increase in the number of people with reactive depression and anxiety, particularly since the collective experience of the COVID-19 pandemic and subsequent lockdowns. While these people genuinely need help with their mental health and wellbeing, there is a concern that those with ongoing diagnosed mental illness cannot access the care that they need and are at risk of getting lost in the system.

8. How successful have Primary Care Networks been in facilitating joined up working between primary and community care provision, and other parts of the system? Are you aware of any alternative models elsewhere? What proportion of primary and community care services are accountable to local and regional level?

8.1 It is important to note that no two Primary Care Networks are the same – there are many different models across the country and it is difficult to generalise about how successful they have been. It is also unclear to BGS members working in primary and community care what role PCNs have in the integration of primary and community services. In many areas, PCNs simply represent another model of managing contracts and have not been allowed to evolve to provide a meaningful function. Where PCNs have been successful, it is often where they have been able to attract investment beyond the standard contract. However, this is not always possible and PCNs are failing in a number of areas with some PCNs having dissolved. Many clinicians feel that the PCN model provides additional work without additional benefit.

9. To what extent could improved access to out of hours and 24/7 services contribute to alleviating pressures on the health system?

9.1 BGS members report that it is not clear that there is a significant demand for extended access with most access problems occurring during standard working hours. The largest group of patients for primary care is older people who, for the most part, are likely to be able to access healthcare services during the week. The provision of additional appointments out of hours reduces capacity across the system to provide care during core hours.

9.2 In addition, the system is not currently set up for equitable care at the weekends as patients cannot access any additional services they may need. For instance, a patient may be able to see a GP at the weekend but if they require blood tests or imaging, they are likely to be required to return during the week as these services are not available at weekends.

10. To what extent have Integrated Care Systems (ICSs) been able to deliver the aims they were set up to achieve? To what extent are they sufficiently equipped to support the delivery of local priorities relating to better prevention and early intervention? To what extent has primary and community care relied on the voluntary sector, and how appropriate has the balance been?

10.1 BGS members believe that there is too much regional variation between ICSs and that systems are not yet mature enough for us to be able to provide an answer to this question.

11. Could you provide examples of how primary and community care have contributed to tackling health inequalities, including international comparisons? To what extent does the picture vary across England, for instance between urban, rural and coastal areas?

11.1 No response

12. In what way could the existing infrastructure be enhanced to improve the use of health technologies, and what are the possible benefits for patients. What are the main barriers to increasing the sharing of information and data across different health services? What can be learned from approached to using technology during the COVID-19 pandemic? How could technology harness ways to empower patients to take responsibility for their own health?

12.1 As detailed in point 3 above, currently the lack of IT infrastructure and data sharing systems across the NHS and social care hampers the delivery of care for patients. Often this involves basic infrastructure such as the lack of WiFi in hospitals and care homes and an over-reliance on paper forms, but there are also inter-operability issues between different systems. Without addressing these basic concerns, efforts to incorporate digital technology into the delivery of healthcare will never deliver to their full potential.

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

13.1 Investment in basic IT infrastructure and systems to share patient data across providers (as detailed above) would have the greatest impact on the delivery of patient care in primary and community settings.

Thank you for the opportunity to contribute to this important inquiry. If you wish to discuss anything in our submission or to invite a member of our Community and Primary Care Group to give oral evidence to the inquiry, please contact our Policy Manager, Sally Greenbrook (s.greenbrook@bgs.org.uk) to make arrangements.

Yours sincerely,

Dr Holly Paris
Co-Chair, Community and Primary Care Group