NHS Providers briefing: Developing models in primary care

Delivering care closer to home is a central pillar of the NHS Long Term Plan, which committed the NHS to spending a growing share of overall spending on primary and community healthcare services. The Plan also set out ambitions to dissolve the historic divide between primary and community health services and create “fully integrated community-based health care”.

These ambitions can only be delivered if they are underpinned by sustainable primary care, however primary care services are facing severe workforce and capacity challenges. We are increasingly seeing new models of care emerging as general practice and primary care seek to overcome these challenges, develop more integrated models of delivery with secondary care and other partners and work at scale. This briefing explores developing models in primary care, specifically the findings and recommendations of the GP partnership review report published in January 2019 and the emerging role for Primary Care Networks.

If you have any comments or feedback on this briefing, please contact ella.jackson@nhsproviders.org.

The GP partnership model

Background

Former secretary of state, Jeremy Hunt announced a review in February 2018 to consider the challenges facing GP partnerships, the benefits and shortcomings of the partnership approach, and make recommendations that would “revitalise and transform” the model. The review was chaired by Dr Nigel Watson (member of BMA GPs committee and CEO of Wessex Local Medical Committees). The review report was published on 15 January 2019 and its findings are summarised below.

The number of GP partners is falling as a proportion of the GP workforce and only 37% of GP trainees say they plan to become GP partners (The King’s Fund, 2018). The review cites workload burden and acute recruitment and retention problems as key problems for the sustainability of the workforce, and warns that patient satisfaction with general practice is starting to fall.

About the model

• The GP partnership model has been the main legal structure for GP practices for over 100 years. GP partnerships are independent, autonomous businesses which can hold a General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contract to deliver primary medical services. Around 69% of practices hold a GMS contract, commonly seen as the most desirable contract as it is held in perpetuity, providing stability for service provision.
• There is considerable diversity between partnerships in list size, number of partners, whether partners own or lease premises, the technology they have access to, and the nature and size of the population they serve.

• The partnership model is a very flexible legal structure which means partners can work part time to develop clinical interests, take on system wide roles and allow for family responsibilities. However part time working also presents challenges, for example, as study leave is pro-rata, training is often undertaken in non-working time.

• Some practices with hierarchies offer progression schemes, for example, where the managing partner takes on more of a business leadership role.

Benefits

• Cost-effective: for the most part, income is set by the services the practice is contracted to provide which offers a strong incentive to run an efficient and effective service.

• Capitated budgets based on the registered patient list are cost effective (however the lack of alignment with secondary care funding mechanisms often causes issues when local system partners seek to agree priorities or progress integration).

• The partnership model engenders a long term and deep understanding of local population needs, and GPs can provide continuity of care often across generations. However continuity of care is seen as one of the areas most at risk given the challenges facing general practice.

• Their small size can give practices the freedom and flexibility to innovate.

Disadvantages

• GPs say the increasing level of personal risk is a major factor for not joining partnerships or leaving them early, particularly the risk of ending up as the ‘last partner standing’ (when all risk and liability sits with the last partner remaining when all others retire or resign). The financial risk for individuals largely sits in premises ownership or lease holding but is also associated with medical indemnity and the personal financial risk of being an unlimited liability partnership.

• Partners are personally responsible for the liabilities of the business, for example, indemnity costs, remises costs, staff costs (although government has announced reform of the GP indemnity scheme).

• Locums and sessional GPs report that the risk, workload and perceived lack of flexibility are all reasons why they did not want to take on partnerships.

• Feedback to the review was that there needs to be a reasonable differential between a salaried GP and a partner, reflecting the responsibility and workload associated with being accountable for a registered population and for running a small business.
Recommendations

The GP partnership review recommends that:

- NHS England (NHSE) should develop proposals to mitigate the personal risk associated with being a lease holder or property owner; and provide support and guidance to partnerships on property ownership.
- The Government should introduce the option of GP partnerships holding a GMS or PMS contract under a different legal model, such as Limited Liability Partnerships and Mutuals.
- A new employment opportunity for newly qualified GPs, a Primary Care Fellowship, should be launched by NHSE and Health Education England (HEE).
- Career opportunities and training for GPs must be improved, including specific training on leadership, quality improvement and management, and opportunities to develop specialties.
- Ongoing action by the Government, General Medical Council (GMC) and other national bodies is needed to streamline and simplify the process by which doctors are able to return to the UK to practice after working abroad for an extended period of time.
- A review of the current pensions arrangements for GPs is required – national changes to the annual allowance and lifetime allowance for pensions have had a significant impact on GPs, as for senior and experienced staff within trusts and other parts of the health sector.
- Medical training should involve a greater amount of time spent in general practice.
- NHSE and others should continue work to reduce unnecessary bureaucracy relating to the primary and secondary care interface; contracting; disputes with NHS Property Services, and CQC processes.
- NHSE should introduce a requirement for all STPs and ICSs to have a primary care plan developed in conjunction with the Local Medical Committees in that area.
- Progress on implementing new approaches to digital, technology and IT equipment.
- There is a clear case for partnerships and GPs to be the building blocks and leaders within local healthcare systems. Despite the development of new models of working at scale, GPs feel they don’t have a seat at the table when it comes to discussions about system planning and general practice has struggled to find a united voice within Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICCs).
- NHSE should support the creation of population-based multi-professional teams across primary and community care. The review suggests that multi-professional community health teams should be based in Primary Care Networks (PCNs) and work under the clinical and service direction of the PCN. They could remain employed by their existing employer while being more closely partnered with, and embedded in, practices day to day. This is explored further below.

Primary Care Networks

PCNs, which tend to cover a population of 30-50,000 people, are one model of collaboration at scale between GP practices. There is evidence to suggest that they have grown in number over the last three years as a result of a focus on national policy level on new models of integrated care and the need for primary care to operate at scale.
PCNs and the GP partnership review

- The GP partnership review concludes that the future health system will operate more in primary and community care settings. PCNs should form one new route for additional resources to be invested directly into general practice, as part of the NHS Long Term Plan (the Plan) shift of funding into primary and community care. Funding for extended access and opening could be allocated through PCNs.
- The review says NHSE should support emerging PCNs to make better use of the existing community health services workforce to support practices, by working more effectively with community health teams and by enabling the creation of population-based multi-professional teams across primary and community care. It suggests that multi-professional community health teams should be based in PCNs and work under the clinical and service direction of the PCN. They could remain employed by their existing employer while being more closely partnered with, and embedded in, practices day to day. This should include creating a single team using a common health record, sharing the same caseload, and removing the need for referrals. Wherever possible, the community team should also be co-located with the constituent practices of the network. NHSE, in partnership with other bodies such as Training Hubs, will need to support PCNs and community health services to work together more effectively and become more than the sum of their parts.
- The development of PCNs should align with an increase in the capacity and range of healthcare professionals available to support patients in the community, through services embedded in partnership with general practice. There is a need for further development of roles based in general practices such as advanced nurse practitioners, pharmacists, practice nurses; and further development of community psychiatric nurses to bridge the divide between GP and mental health services. Other NHS staff such as paramedics, care coordinators and social prescribers could make a positive contribution to general practice workload.

PCNs and the NHS Long Term Plan

The Plan sets out ambitions for the creation of “fully integrated community-based health care” and advocates the roll out of PCNs aligned with expanded community multidisciplinary teams. As part of a set of multi-year contract changes individual GP practices in a local area will enter into a network contract, as an extension of their current contract, and have a designated single fund through which all network resources will flow. Local contracts for enhanced services will normally be added to the network contract.

Clinical commissioning groups (CCGs) have been told that they must have PCNs in place by 30 June 2019. The 2019/20 planning guidance says “Building on the £3/head CCG investment in primary care transformation during 2017/18 and 2018/19, we will be requiring CCGs to commit a recurrent £1.50/head recurrently to developing and maintaining primary care networks so that the target of 100% coverage is achieved as soon as is possible and by 30 June 2019 at the latest. This investment should be planned for recurrently and needs to be provided in cash rather than in kind. More guidance on the future direction for primary care networks will be available soon.”
The Plan also set out further details about the expectations for PCNs:

- From 2020/21 PCNs will be expected to assess their local population by risk of unwarranted health outcomes and, working with local community services, make support available to people where it is most needed. The planning guidance set out that STPs/ICSs must ensure that PCNs are provided with primary care data analytics for population segmentation and risk stratification, according to a national data set, complemented with local data indicator requirements, to allow them to understand in depth their populations’ needs for symptomatic and prevention programmes including screening and immunisation services. PCNs will be required to help improve early diagnosis of patients in their own neighbourhoods by 2023/24.
- PCNs will contribute to ICS plans through representation on the ICS partnership board.
- PCNs will be offered a new ‘shared savings’ scheme from which they will benefit from actions to reduce avoidable A&E attendances, admissions and delayed discharge, streamlining patient pathways and over-medication.

**NHS Providers view**

Trusts tell us that primary care service is their most important partner and that closer working with general practice, social care, and wider community service is fundamental to the sustainability of the NHS, and to developing high quality, integrated services for local populations.

PCNs provide one helpful model to enable primary care to operate at a larger scale. However we know there are many other models being developed and tested across the country which offer similar benefits, including structural integration with trusts, the formation of GP federations, and super practices (which some argue offer greater potential for patient benefit and economies of scale), and new models within primary and acute care systems (PACS) and multi-specialty community providers (MCPs). In our view, it is important that local areas are allowed the flexibility to develop models and ways of working that best suit local needs and context.

It is inevitable that some PCNs will develop more quickly than others and there is a danger that mandating one model may not allow the flexibility or time that is needed in some parts of the country. There are parallels and opportunities to learn from the recent experience with STPs and ICSs here. As we described in our briefing on system working, we know that the most successful examples of collaborative working are those where there are quality relationships between organisations, the quality and capacity of local leaders, a collective commitment to prioritise the needs of patients and the system, a ruthless focus on a small number of practical priorities and a culture of pragmatism meets continuous improvement.

We expect the plans to develop PCNs to become clearer with the publication of the new GP contract. However, given that some areas of the country are not yet covered by PCNs, there is a risk that the ambitions set out in the Plan are not based on realistic assumptions about how quickly PCNs will be able to become established and take on these new roles. As PCNs are not statutory bodies it is unclear how they will be able to take on some of the responsibilities suggested in the Plan, such as becoming employers or budget holders, and be held to account. It is also unclear whether PCNs will have the
capacity and capability to deliver on the ambitions for them, and how they will be funded in the long term.

We look forward to working with the national bodies and our partner organisations in primary care as the plans for PCNs progress and will be sharing examples of good practice to capture how different care models are developing and operating with strong primary care and community services at their core.

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