Comments from General Practitioners about NHSE's Long Term Plan, Primary Care Networks and Integrated Care Providers April 2019

GP1 I feel a bit torn about PCNs. My first gut feeling about them has been positive – I've been frustrated by the lack of joint working locally in recent years – and I agree with the principle that unless these arrangements are written into contracts/funding then collaborative working won't happen. I think there is lots of potential to work together with neighbours and though I see lots of merit to the Partnership model, it does mean that GPs work in an isolated way, and good/innovative practice isn't easy to share at all. I also feel that there is a large cohort of GPs who are very resistant to change – this is understandable as levels of cynicism and burnout are very high. But there's often a kneejerk 'no' when new ideas come along that involve any kind of change.

So although I generally have welcomed any push for GPs to work together; this is tempered by my own cynicism about the direction of travel more generally – that everything I see coming out from the DH at a high level seems to be wilfully ignorant of the kind of relationship-based-care that is the cornerstone of GP, both in terms of popularity and efficiency. Our Practice Manager is generally a level-headed and pragmatic voice that often challenges some of my own cynicism and scepticism about various new schemes. She is very worried about the direction of travel with the PCNs, and predicts that an increasing share of funding will be tied to the networks over coming years, leading to a situation where all funding is going to the network, not to individual practices. I haven't been able to look into this as much as I'd like, but if she's worried, I am too.

I'm struggling to come down on one side of the fence on this one. I'm glad to see it happening, but I don't trust the motives of the folk at the top....

GP2 There are some potential benefits to PCNs, and clear risks. However, I do not think they are risks that KONP could sensibly campaign on. I think a much better target would be the pressure on CCGs to merge. If the 6 South East London CCGs merge to form one massive CCG (which is looking increasingly likely) that will significantly weaken the local voice and our ability to influence decision making. By this I mean all of us: patients, LMC, activists, other NHS staff. OHSEL ('Our Healthier South East London – STP partnership) are already seeking to set rules ("principles") which they want to use when making decisions about whether to "assure" PCNs.

MY THOUGHTS AND QUESTIONS ABOUT THE PROPOSED PRIMARY CARE NETWORKS

Whilst always welcoming additional funding in primary care, we have seen that when it arrives with many strings and caveats attached it is not always efficiently spent (GPFV....) and I want to express some significant reservations. **These are:**

- It is pre-specified how most of the funding will be spent: the various non-doctor roles which are reimbursable have been listed;

- the seven national specifications have yet to be written, but it looks as though we will have little flexibility.
- Although we will technically be paid £1.76 pwp for participating in the network, other changes to the global sum mean that it goes up by only £0.92 from last year. This is likely to be eaten up by increased salary costs for existing staff.
- The money for the extended hours DES, which is to be taken on by the network, has reduced from £1.90 to £1.45 pwp.
- Allied health care professionals are good to have, but do not work as quickly as GPs and require training and clinical supervision, which takes GP time.
- Further GP time will be taken up in the 0.25 WTE required to run these networks – I calculate this is equivalent to **270 WTE GPs** for the whole of England.
- There will be multiple meetings to sort out how we will work together. It took the Federations a good couple of years to establish clinical governance processes, HR and employment processes, agreed structures, ways of working and decision making.
- I see little benefit in doing all this again for groups of 30 - 50k patients when we have a borough-wide structure which is just about maturing.
- In addition to time, it will cost actual money: facilitators, organisational development, accountants, lawyers fees ...
- Much of proposed national specifications we have already done or are doing (medicines optimisation, CVD prevention and diagnosis); or the evidence base is poor/non-existent (personalised care, anticipatory care); or is not amenable to NHS intervention (tackling neighbourhood inequalities) – so in the absence of significantly improved funding of social care and public health, I have very *little confidence that outcomes will be improved*.
- It is far from clear that new staff actually exist to take on all these roles. The most likely thing is that staff will either be poached from hospitals or will be subcontracted/work under SLA from the trusts currently providing community services (GSTT have already offered this!)
- Even if the staff can be found, they will not replace GPs, any more than practice nurses did. We will still have significant shortages of GPs and practice nurses, and even if we can find them, there is no new funding to pay for them (none of the DES money is for nurses/GPs).
- There is nothing about estates in this strategy: in a BMA survey 50% of GPs said their premises are not suitable for present needs, and 80% said they would not be suitable for future needs. Where are all these new staff going to work?
- As an experienced GP, I feel able to supervise newer GPs, pharmacists , nurses, HCAs and reception staff, but I am not qualified to clinically supervise nor quality assure the work of other staff eg physiotherapists, mental health practitioners. How will this work? More complicated subcontracting?

- I also struggle to understand the structural models suggested. I do not know how you can have shared contracts ie one person with many employers. How do you line manage? Which T&Cs are used? who takes on sick pay, maternity pay, performance

management? And the nominated practice who receives the funding is put in a strange position. Even if the money just goes in and out of the account, it will have to appear on the practice accounts, which will affect turnover, possibly profits and tax, and will require administration. So, there is risk for the lead/nominated practice, but also for the other practices: what if the lead practice goes bust? There is no explicit funding for administrative support, and we have been told that the clinical director salary cannot be used for this. If a dedicated vehicle is set up (eg a Ltd Co, or a CIC) then the liabilities are less and more clear, but there are then problems with VAT and staff not being able to access NHS pensions ... We are advised to be careful how we set up our networks and write the schedules for our network agreements to avoid these problems, but we are clinicians, not lawyers not accountants: I foresee lots of money will be spent paying lawyers to write the schedules we need and asking accountants for financial advice. And all within a very tight timescale.

- The whole thing strangely undermines the "at-scale" structures we have been persuaded to put in place in the last few years. In our borough, we started with 3 federations which turned out to be too small, and they have painfully and expensively merged (more money for lawyers and accountants). The contracts they hold they largely run at cost and have been funded from the £1.50 which CCGs were required to invest in primary care transformation. Now that is being taken away to give to PCNs the financial model of the Federation is undermined.
- I think there are some services eg the (8-8 Access Hubs, some sexual health) which are best run at borough level. If they survive, that will mean a complicated structure of practices: PCNs – Federation – CCG. If they do not survive, that will mean all the time, effort and money in setting them up was largely wasted, and we will go through the whole process again at PCN level.

- I do not know if we would have to accept all the future specifications. Probably not, as (for example) not all PCNs will have a care home in the area, so will not be able to offer a care home spec. There are some things which have been suggested which I would definitely NOT want to take on: e.g. "gainshare" agreements, prescribing budgets.
- So why did GPC agree this? I think they like that it seems more GP-led, that it is not an ICP, that it preserves the GMS contract; and it was perhaps a trade off with other changes such as indemnity (this is a big thing), funding for SAR, changes to QOF etc. Also there is a degree of desperation: practices are closing at an alarming rate, and those that remain are merging to try to protect themselves. Working in a small practice I am very aware how vulnerable we are to minor vicissitudes such as staff illness/pregnancy. But I fear if ever more money goes via the PCN then the GMS contract could just wither away. Independent contractor status has allowed us to say "no" to all sorts of rubbish in the past, and GPs have found it easier to speak up than employed hospital doctors, so I think this would be a real loss.
- Personally, I do not think we need /any/ new structures to co-operate and collaborate: we just need good communications and properly staffed services!

GP3 I have described PCNs as 2 headed. On the one hand they are there to support GP but the other hand they are supposed to help implement the long term plan. They do truly allow individual Practices to hold power and decide strategy for their neighbourhood in a way that eg CCGs did not. However, this can only happen if there are able leaders within each and every PCN otherwise (some people's) paranoia may begin to become reality."

GP4 I'm inclined to scepticism – I fear it may be a step on the way to loss of autonomy but I'm not as much of a conspiracy theorist as some.

GP5 I think it depends on the details of any contract between the practices and the PCN. I have a colleague who'll probably be leading the PCN in one borough. He has no idea whether there'll be a contract at all or, if there is going to be one, what kind it might be. So, I think it's very unclear at the moment but they are Primary Care Home repeated across the country, I think it'll be rather good. And, in all cases, much will depend on relationships in the patch - as always ...

GP6 I think the idea is potentially very exciting and could lead to a renaissance of general practice. It creates an entity that is big enough and potentially strong enough to counter secondary care and to ensure people are looked after more appropriately. I am concerned about GPs ability to make it work but I don't agree that it is a dark trick to privatise.