Primary Care Networks KONP Discussion Paper

General practice across the UK is in deep crisis.

Over the past decade funding for General Practice has fallen in real terms; there are fewer GPs because of reduced recruitment and retention, in part due to impossible workloads and soaring stress levels; and many practices have been forced to close. Patients are unable to get appointments to see a GP for weeks, and are even less likely to see a GP that they know and who knows them personally.

This is tragic because British General Practice, based on the principles of personal, continuing, community-based care, **has proved over many decades to be clinically effective, efficient** and popular. Not only has it enjoyed high levels of patient satisfaction, with patients consistently expressing their preference for personal continuing care with a GP they know, but there is strong evidence that **"continuity of care" saves lives [1] and protects patients from unnecessary and harmful interventions [2], thus being cost effective as well as clinically safe and effective.** Yet, despite the remarkable achievements and popularity of this system of care, **Government policy over the past decade has actively undermined General Practice** and led to the crisis that it currently faces.

Successive government policies in England have underfunded General Practice (funding policy in England inevitably also determines funding for the NHS in the other UK nations) and undermined its core essence, in particular continuity of care, by favouring "access" at the expense of all other values, by promoting a corporate model of GP provision and by promoting "General Practice at scale". As a means of survival many GPs have opted or felt coerced into merging with giant "super practices" of hundreds of thousands of patients. Others have chosen to be employees of large corporate GP providers, being moved from location to location and developing no deep or long-term connections with patients or communities.

This process began in 2004 with the Labour Government's changes to the GP contract, allowing non-GP corporate organisations such as United Health, Virgin and Care UK to provide General Practice services, and has accelerated since 2010 by government policy, which selectively encouraged and promoted "General Practice at Scale".

"Entrepreneurial" GPs have created mega GP organisations such as the Birmingham-based Modality with over 380,000 patients, the Hurley Group with over 100,000 patients and the rapidly growing GP at Hand, with over 40,000 patients and counting. There is no evidence that these mega practices are more clinically effective or acceptable to patients. Rather they are a response to the desperation of many GPs and the opportunism of others.

It is no mystery that **this has correlated with a decline in patient satisfaction** with General Practice **and a decline in the popularity of General Practice as a medical career, contributing to the crisis it now finds itself in.**

---

[1] https://bmjopen.bmj.com/content/8/6/e021161
[2] https://www.bmj.com/content/356/bmj.j84

Primary Care Networks

It is against this background that NHSE has agreed a new GP contract with the profession that claims to address some of the major issues affecting General Practice, especially funding and staffing. One aspect of this new contract **– Primary Care Networks (PCNs) –** has attracted a lot of attention.

Some GPs welcome PCNs because they feel they will direct extra resources into and help reinvigorate General Practice; others are more sceptical – summed up by one GP whose views I sought:

> *'another nail in the family physician coffin'*

Another GP expressed the ambivalence many others feel:

> *'My first gut feeling about PCNs was positive. I think there is lots of potential to work together with neighbours so I generally welcome any push for GPs to work together, but this is tempered by my own cynicism about the direction of travel more generally – that everything I see coming from the Department of Health at a high level seems to be wilfully ignorant of the kind of relationship-based care that is the cornerstone of general practice, both in terms of popularity and efficiency.'*

What is the Primacy Care Network contract?

Under the PCN contract practices agree to link up with other local practices in groups of 30-50,000 to form a Primary Care Network. The Primary Care Network (PCN) contract is an extension to the basic GP contract and is known as a **Directed Enhanced Service (DES)**. DESs have existed for many years and are used by NHS England as a contractual mechanism to get GPs to do things over and above their core contract requirements. GPs have until 30 June to sign the PCN contract.

The Primary Care Network contract *will not affect the core GP contract* (known as the GMS or PMS contract) with its registered list of patients.

Practices will not have to give up their patient lists to the PCNs, and patients will still be registered with their individual practice and receive core medical services from their existing practice team.

This means that PCNs are very different to the proposed Integrated Care Provider (ICP) model, promoted by NHS England (NHSE), and which KONP vigorously opposes, whereby GPs would give up their practice contract and patient list and merge into a massive organisation covering upto hundreds of thousands of people.

BMA GPC chair Dr Richard Vautrey said:

> *'We have made our serious concern about the impact of ICPs known repeatedly and we continue to do so. These proposals (ICPs) would undermine the positive potential that working together within primary care networks, based on the existing GMS or PMS contact, could bring.* ***There is no need for practices to give up their contract to be able to develop***

> ***sensible collaboration with local NHS services and put in place improved community-based services as a result**.'*

PCNs are therefore seen by many GPs as a way of protecting themselves from pressures to be subsumed into larger organisations such as super-practices or ICPs, **enabling them to retain the benefits of smaller scale practice size at the same time as supporting them to work with neighbouring practices to provide a wider range of services.**

GP collaboration is not new

GPs working together in larger groups across a neighbourhood is not new. There have been various versions of this over the years from Total Purchasing Pilots, Neighbourhood Networks, Fundholding groups, Practice Based Commissioning, Primary Care Groups, GP Federations and more, all designed to get GPs to collaborate. They all seem to follow the same pattern of rise and fall, starting with great expectations only to disappear without trace, depending on changes in government policy. So most GPs are approaching the advent of PCNs with a certain amount of cynicism. However, cynicism apart, virtually all GPs will end up signing the PCN contract because it is the only way for practices to get the extra funding they desperately need, and if they don't sign up they stand to lose money, through loss of funding for extended hours.

Funding

The increased funding promised to General Practice is **not enough to make up for the loss of £1 billion/year over the last decade**. Most of the extra funding in the new GP contract will not go into core GP services but into Primary Care Networks – a total of £1.8 billion a year by 2022.

In return for signing up to the PCN each practice will be paid £1.76 per patient on their list. Further payments will be paid directly to the PCN. This will include £1 per patient for all practices in the PCN; funding for clinical pharmacists, and social prescribers in the first year; and funding for a PCN clinical director to work one day a week for the PCN.

In future years there will be funding for physiotherapists, physicians' associates and paramedics. These staff will be shared across the practices in the PCN, but may be employed by a lead practice.

There will also be seven national service frameworks setting out targets for care delivery that the PCN member practices will have to demonstrate they have achieved together.

Stated aims of PCNs

The stated aims of PCNs are to tackle the crisis in General Practice, in particular the **crisis in recruitment and retention of GPs**, by deploying a wider range of health care workers to 'take the pressure off GPs'; to encourage GP practices to be part of wider multi-disciplinary teams to deliver improved community-based care, thus reducing demand on hospitals; and to incentivise GPs to work together to tackle wider health issues, and to reduce health inequalities, as outlined in the NHS Long Term Plan.

The PCN ideas of greater collaboration between practices, multi-disciplinary team working around the patient – especially the most complex and vulnerable – and a wider range of practitioners to provide patient care, are being welcomed by many GPs. They hope it will help to rebuild and enhance the primary care teams that used to exist, when other types of practitioners such as District Nurses and Health Visitors worked closely with GP practices (before a previous wave of policies broke them up!)

Will PCNs be able to rescue General Practice from collapse?

A **wider range of practitioners** could usefully complement the role of GPs, just as practice nurses do. However they won't solve the GP workforce crisis. There is already a shortfall of 7000 GPs. **As primary medical care becomes more complex,** and more and more work that was previously done by hospitals, such as the care of people with long term conditions, is transferred to General Practice (this process started three decades ago), **there is a need for more GPs, not fewer.** Even if some of the new practitioners relieve some of the GP workload that will make very little difference to the overall shortage of GPs.

Furthermore, given the NHS staffing shortages with over 100,000 vacancies, it is unclear where the proposed non-GP staff (physiotherapists etc.) will come from. It is likely any such staff will be taken from the already reduced NHS staff pool i.e. poached from hospitals or seconded from existing community providers.

The wider goals of PCNs, of improving health, reducing hospital admissions and reducing health inequalities, seem unrealistic too. Severe **cuts to public health, preventive services, social care and community services have undermined** the possibilities of improving care in the community. Add to that the on-going impact of auster**ity, poverty and inequality** and it seems unlikely PCNs will have much impact on health inequalities, given that they have no power over those wider issues.

But **being unrealistic never prevented previous grandiose NHS schemes.** As the Red Queen said to Alice *one can believe 'as many as six impossible things before breakfast' – one just needs to practice!*

Risks

And what about the risks?

Diverting further resource away from GP frontline care

Not only are PCNs not the solution to the GP workforce crisis, **by diverting resources from core General Practice that could be used for the recruitment and retention of GPs, PCNs are adding to the GP staffing problem.**

Many GPs fear loss of autonomy from PCNs, especially if more and more funding is funnelled through PCNs rather than directly to practices, thus allowing for more centralised control and depriving practices of the resources to determine their own ways of doing things.

Some GPs see PCNs as yet another reorganisation taking up precious GP time and wasting resources. Each PCN will take up the time of a GP in the Clinical Director role for one day a week. Across the country, this would be the equivalent of about 270 GPs taken from front line care. That is in addition to GPs continuing to be involved in other structures such as Clinical Commissioning Groups and GP Federations.

Irresponsible inducements for GPs not to refer to hospital

The proposal that any savings from reduced A&E usage or hospital admissions would be shared with PCNs is irresponsible and unnecessary. Similar schemes in the past have proved futile and only served to sow distrust in patients towards their GPs – patients could no longer be sure their GP was acting in their best interests. In any case NHSE admitted in the Long Term Plan that they don't expect there to be much reduction in projected hospital usage.

Improved community care is a good thing in its own right and if it also reduces unnecessary hospital usage then all GPs would recognise that as a good thing – they don't need financial incentives for that – they just need community care to be properly funded.

PCNs and the Long Term Plan

The statement in the NHS Long Term Plan that PCNs will be the 'building blocks' of bigger Integrated Care Systems (ICSs) – systems of health care planning and provision covering populations of up to a million people – is a cause for concern. This is especially so if Integrated Care Systems go on to spawn Integrated Care Providers (ICPs), otherwise known as Accountable Care Organisations (ACOs), with all the attendant risks of privatisation, rationing of care and loss of public accountability that KONP has already highlighted.

But PCNs progressively merging into bigger organisations and ending up in ICPs (ACOs) is not an inevitable outcome – there would need to be a lot of other changes and stages before that. As explained above, PCNs do not affect the basic structure of general practice with its registered patient lists and general medical services (GMS) contract. PCNs are thus quite different from ICPs whereby practices give up their GMS contract and hand over their patient list to the integrated care provider trust. There is no automatic conveyor belt between PCNs and some bigger, potentially privatised conglomerate such as an ICP. **Whether a final apocalyptic possible future actually happens or not is dependent on the outcome of political forces, resistance and popular struggle. Nothing is inevitable.**

What's more, it is wrong to suggest, as some have done, **that this has already happened** – that practices signing up to PCNs entails them signing away their patient lists to a prototype of an ACO and the end of General Practice as we know it. To suggest that is to say we have already lost the fight when we have not – not by a long way. And **to say we have already lost prevents us from fighting effectively to defend what we still have.**

PCNs are not the 'bogey man' that is going to destroy General Practice, but nor are they likely to be the knight in shining armour. The great risk to General Practice comes not from PCNs but from the ongoing crisis in General Practice, through loss of funding and staff, which has already forced hundreds of practices

to close or merge into super-practices, or have their patient lists taken over by big private providers, with tens of thousands of patients losing their right to a personal GP.

What should KONP do?

KONP has not traditionally taken up the cause of defending General Practice and there are several possible reasons. One of these may have been ambivalence about GPs because they are independent contractors – seen by some as 'private'. There is much to debate about what the ideal model of General Practice might be, with some socialists calling for a salaried service while others arguing that what has developed over the decades is, in all practical senses, an NHS service. But it is clear that currently a salaried GP service that preserves what is good about traditional General Practice is not on the cards **and what is facing us now is the replacement of traditional General Practice with something worse: more corporate, more remote from patients, less caring and less effective.** If KONP wants to defend the NHS and all that it means for patients and the public then **we need to defend General Practice**, even if we can imagine a better way it could be organised in future. That means **we need to campaign around a set of demands that patients, public, GPs, practice nurses and other primary care practitioners can support.**

I don't think there is any value in campaigning against PCNs. For a start virtually all GPs will sign up to them – in practice there is no choice and it would be pretty suicidal for practices not to. Secondly some GPs, including progressive left GPs, see PCNs as a potentially positive development. Some patients and members of the public too are likely to welcome the idea of increased investment in community-based care. Thirdly, the **risks some see in PCNs** – of them being a stepping stone to Accountable Care Organisations – **are not inevitable *and* are amenable to political resistance.**

Instead of campaigning against PCNs I believe **we should campaign positively for demands that will ensure the future survival of the form of General Practice that delivers what patients want and that has proved its worth**, based on the values of personal, continuing, community based care, **and continue to oppose moves towards corporate models that undermine those values** and in particular to oppose Integrated Care Providers, Integrated Care Systems and Accountable Care Organisations.

Louise Irvine GP in Deptford, South East London May 2019

Chair – Save Lewisham Hospital Campaign; KONP steering group delegate

See appendix below: KONP Primary Care Charter – GP services in the NHS: our demands

Appendix: KONP Primary Care Charter (DRAFT)
GP services in the NHS: our demands

In campaigning to restore Primary Care, we say:

FUND THE GP CURRENT MODEL THAT GIVES CONTINUITY

- Support the traditional model of General Practice based on personal and continuing care.
- FULLY FUND IT: Significantly increased core funding to General Practice
- Significantly increase numbers of GPs and Practice Nurses
- Stop the move to merged corporate super-practices

SUPPORT GPs and OTHER PRIMARY CARE STAFF

- Manageable workloads for all staff
- Support staff wellbeing and prevent dangerous stress

BETTER ACCESS FOR PATIENTS:

- Prompt access to your GP – end long waits for appointments
- Prompt access to your Practice Nurse
- Prompt access to other primary health care staff in the community
- Prioritise easily accessible services within a short distance of home

RIGHT TO SEE YOUR GP – FILL THE VACANCIES:

- The right for patients to have face to face appointments with a GP

MULTI-DISCIPLINARY TEAMS ADDITIONAL TO, NOT REPLACING GPs

- Increased numbers of community staff such as district nurses
- Collaborative multi-disciplinary networks, small enough to be sensitive and responsive to local health issues and accountable to local people.
- Adequate wider services to support primary care in the community including social care, public health and mental health services.
- Strong links with local hospitals and improved communication and collaboration between primary and secondary care.

PATIENT & PUBLIC ENGAGEMENT IN PRIMARY/COMMUNITY CARE

- Opportunities for genuine patient and public involvement in the development of community services

(1) https://bmjopen.bmj.com/content/8/6/e021161

(2) https://www.bmj.com/content/356/bmj.j84

Louise Irvine, May 2019