## Primary care update: events are moving fast, and in the wrong direction

What's good for patients Is good for the economy. Primary care investment is crucial for economic growth and pays for itself. Investment in healthcare generally drives a fourfold economic return, but investment in primary and community healthcare, some estimates put much higher. (1)

However recent trends show that patients are increasingly receiving less skilled, fragmented, over digitalised, secretive and privatised care

In addition to 14 years woeful underfunding and understaffing of primary care, with all the rationing and delayed care that has meant for patients, a recent clutch of Conservative government policies will add to the misery and dilute the service beyond recognition.

**These include:**

1. **increasing the under-supervised employment of less qualified practitioners** e.g. physician associates from 2000-10,000, instead of core staff, e.g. GP, nurses, pharmacists, physiotherapists
2. allowing ***private and private equity companies to buy and sell*** primary care practices like chips, even when they flout the terms of their contracts
3. plans to **break up primary care** into same-day access hubs for 'simple' cases with non-GPs (a sort of 111 service for 24/7). This does not recognise the frequent complexity of people with urgent needs, who often get the best care from a team who knows them. It risks duplicating consultations as people will have to rebook with their own surgery and threatens to further reduce patient choice of who they see.

**PHYSICIAN ASSOCIATES** (PAS)
**The government plans to increase from 2000 to 10,000, the numbers of these** unregulated, and often under- supervised and under- supported staff, in over stretched primary care, that lack the resources to provide the support they need. This has resulted in misdiagnosis and treatment delays, sometimes with fatal consequences. See Telegraph and BBC news. So far from 'getting it right first time,' which saves time and money, and increases GP productivity patients are often seen many times, before or if, the right intervention is offered. (4,5,6,) See Kiely, BMJ Public Health; KajariaMontag, Freeman, Scholtes, Management Science; McKeen and Brayne BMJ

Some practices, particularly the larger ones owned by commercial organisations on APMS contracts, are saving money by employing PAs instead of GPs, e.g. Operose practices employ 6 times more Physician Associates compared to the national average, with only 0.6 FTE GPs for every 2000 patients, compared with the NHS average of 1.2 FTE GPs.

The BMA predicts 4000 newly qualified GPs will be unemployed this August due to a nearly nonexistent job market in some areas, particularly the Midlands and northern England. Other GPs are being made redundant; some locum GPs can no longer find work. This is a terrible waste of a major investment in medical training, and a huge loss to safe patient care.

The BMA has produced guidance for safe practice for PAs already employed which includes general principles for safe PA working:

*This is an assistant role to doctors helping with simple practical procedures, administrative tasks, and working with patients in a supportive and specified role.*
*This does not extend to seeing undifferentiated patients in any situation. Primary care sees undifferentiated patients.*

What started as a means to mask doctor shortages has now become a preference. The Additional Roles Reimbursement Scheme which funds PAs and other roles, perversely does not fund GPs.

**What we call for:**

- **Stop the plan to increase PA numbers by 8000, and implement an evidence-based workforce strategy to train, employ and retain the core staff that genuinely improve health outcomes and increase productivity in primary care - GPs, nurses, pharmacists, physiotherapists, mental health specialists, paramedics.**
- **Change the current perverse funding streams e.g. the Additional Roles Reimbursement Scheme to permit GP recruitment, rather than the current rules which incentivise non-medical recruitment.**

**FROM NHS TO PRIVATE SECTOR, TO PRIVATE EQUITY**
**The role of the private sector in primary care's clinical services has increased** since NHSE mandated in 2014 the default use of Alternative Provider of Medical Services (APMS) contracts. However, safe care, continuity of care and service stability, can only exist if supported by long term, committed, not for profit, ownership, organisational, financial and workforce models. Private companies do not deliver this and one of the most recent and egregious examples is that of the Operose sale.

In 2021 **Operose/Centene bought nearly 60 general practices,** covering 640,000 patients, mainly in London, from AT Medics, but sold them in December 2023 because of low profits, despite the 14% premium per patient paid to all APMS contract holders. The new owners are T20 Osprey Midco, part of a complex web of companies, including HCRG (rebadged Virgin Care), with a mixed record providing health services, and all owned by Twenty 20 Capital a private equity company.

AT Medics Ltd continued to hold the contract but knowingly committed a serous contract breach by enabling Change of Control to be transferred from MH Services International (UK) Ltd, a subsidiary of Centene Corporation, to T20 Osprey Midco Ltd., without informing the ICBs, prior to ICB authorisation, and while the due diligence process was continuing.

The due diligence process undertaken on behalf of North Central London (NCL) Primary Care Committee revealed that **not obtaining the ICBs' approval for the Change of Control was factored into the sale pricing model,** and that when the asked for more information about this, they were refused on the grounds of **commercial confidentiality.**

- *T20 Osprey Midco Ltd is a special purpose vehicle company without a track record*
- *New debt was registered against AT Medics and Operose, which Operose reported was a* ***refinancing of the existing debt of the buyer's wider group of companies, so AT Medics is now subject to additional potential liabilities, but the ICB has been unable to ascertain the extent of these***
- *The sale of AT Medics and Operose Healthcare Ltd is a buyout of those businesses by the wider HCRG group of companies and its owners, Twenty 20 Capital***.**

North Central London ICB Primary Care Committee has acknowledged there has been a **serious breach,** and the contract terms empowered them to terminate the contract forthwith. At a May meeting the PCC opted to continue with the due diligence process, and then take a decision from one of the three options they had identified: no further action, allow T20 Osprey Midco to retain the contract and attempt a more rigorous contract monitoring, or terminate the contracts. The PCC thought that the other ICBs would be following a similar process.

However, PCC papers for a meeting In June (10) now recommend terminating the contract, due to expire on 30 June for St Annes' practice, and reprocuring. It is unclear what will happen for the other practice in NCL or those in other ICBs.

KONP will continue to press for termination and new contracts to be within the NHS 'family'. The T20 Capital group's complexity, lack of transparency, and the flagrant breach by T20 Osprey Midco, ensure that the ability of the ICBs to conduct robust due diligence, and if the contracts are retained by T20 Osprey Midco, monitor services, and enforce recommended improvements, is illusory.

Continuing with these contracts is **not in the best interests of patient safety** and service stability. The experience of English Social Care, children's day care, and US healthcare (9) offer compelling evidence that private equity companies' business model, with a ruthless focus on rapid profit maximisation, cost cutting and sale, is a poor fit for the long term, professional commitment primary care needs.

**Evidence indicates that ownership-type influences care quality, health outcomes, and cost. NHS provision and contracts, rather than outsourced private provision, deliver better results in primary care, is more cost effective, and increases productivity. See Cowling, Journal of The Royal Society of Medicine;** Centre for Health and the Public interest; Goodair, Reeves, The Lancet Public Health

**What we call for:**
**Halt these contracts and adopt alternatives. These should include a mix of solutions, tailored to best suit local need and existing strengths. These should all involve NHS bodies as the default provider, with doctor- led contracts, held through ICBs and their GP Federations, or similar. In some localities, hospital trusts maybe in the best position to run some primary care services, *or* the newer Employee Ownership Trusts.**

**3. SAME DAY ACCESS - OR 111 FOR 24/7**
The new operating model for primary care being introduced by some ICBs at the behest of NHSE breaks up primary care into large PCN - wide (40,000 patients) same day access hubs for 'simple' cases, leaving GP surgeries, to see everyone else. **The hubs will be mainly staffed by non-doctors using an algorithm triage system. NW London's adoption of the system met with fierce opposition from patients and clinicians and been temporarily paused.**

**NHSE cites the Fuller Stocktake report on primary care as the inspiration for this development and is pushing ahead.** Oxfordshire, Buckinghamshire, Berkshire, Hampshire and Isle of Wight are also introducing the system, along with seven more ICBs where they are badged as pilots. In the pilots the ICBs will plan to evaluate how primary care can better use digital tools to target the most vulnerable; automate complex processes; and risk stratify populations.

The seven proposed areas are: Suffolk & NE Essex (lead), South Yorkshire, North Yorks & Humberside, NC London, Gloucester, Somerset, Lincolnshire. There has been no consultation on this change to services.

The original NW London plan was to ban GP practices from offering same day appointments, divertng patients to same- day triage hubs, staffed by non-medical staff bar one GP. These staff were to be drawn from local surgeries, forced to sign up to the programme, or lose a significant part of their income, and be left with the bulk of algorithmically designated complex patients. The mandated component has apparently been dropped, but the financial carrots and sticks appear intact.

A recent study advocates strongly against the prioritising access over care continuity, and the separating of same day care form longer term care in general practice. The additional funding attached to this policy would be better spent supporting GP practices.

**We call for**

**A halt to Same Day Access policy:**

- **it fragments primary care and further erodes continuity of care, (which saves lives, patients' and GPs' time, and boosts GP productivity),**
- ***and* it condemns patients to a less skilled diagnostic first contact, likely to delay the care they need, until they see their GP, and therefore wastes time, duplicates effort and costs more.**
- **Give the additional funding to PCNs and practices to improve access and care continuity in the manner best suited to their local circumstances.**

**Brenda Allan 12.06.24**