Primary Care Network
NHS Confederation

Supporting general practice at scale: fit for 2024/25 and beyond

October 2023

About us

NHS Confederation

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Primary Care Network

The Primary Care Network is part of the NHS Confederation. It supports, connects and empowers primary care members to maximise the impact they have on patient care and drive change.

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Key points

- This report summarises the key findings from our engagement with Primary Care Network members on the state of general practice and primary care more broadly. Through this work we have identified local innovators breaking down barriers and untapped potential in integrated working, as well as bureaucracy slowing down improvements and variation in the parity of esteem between primary care and other system partners.

- As a result, we have identified a set of tangible recommendations for the upcoming GP and primary care network (PCN) contracts for 2024/25 and a series of non-contractual recommendations that we believe will enable general practice and at-scale primary care to best deliver for patients in the short and medium term. The overarching focus of these recommendations is to:

    - Increase trust and flexibility through the contracts so primary care can deliver for local people based on local needs, with a key focus on prevention and addressing health inequalities.

    - Support the basic infrastructure with dedicated funding and funding uplifts that mirror the rest of the system.

    - Make primary care a more attractive place to work.

    - Where possible, use contractual and non-contractual levers to make it easier for primary care to work with the rest of the system within a local community.

Background

General practice and primary care networks embody a culture of cradle-to-grave care, emphasising relationship-based care, generalist expertise and multidisciplinary teams to improve population health. As health and care needs become more complex and the challenges in health and care change, we must strive towards a whole-person approach to care delivery: delivering more services closer to people's homes, personalising care, preventing ill health and addressing the wider determinants of health.

The introduction of integrated care systems initiated through the NHS Long Term Plan and formalised in the Health and Care Act 2022 has helped progress this shift. But, for local leaders trying to drive changes, more is needed to support implementation of integration and collaboration, with associated investment required to deliver the ambitions of integrated systems. To contribute meaningfully to system development, primary care needs to be treated as an equal partner in relation to strategic planning, resource allocation, workforce and digital enablement.

As a recent report from the NHS Confederation's ICS Network acknowledged:

> **"Both ICS and primary care leaders are clear that PCNs will need the autonomy and support infrastructure to allow primary care leaders to play a more active role in ICSs…There is clear commitment to primary care at scale and a recognition of the important role that primary care can have at different levels".**

As we approach the end of the five-year framework for general practice and PCNs, the uncertainty has been difficult for primary care leaders and their staff, who rely on national contracts for business planning and continuity. We recognise the cultural issues that need to be addressed and we need greater recognition of primary care's changing, adaptive and innovative abilities within the system.

However, the barriers continue to make this challenging, so this report recognises the need for realism and honesty in looking at the immediate priorities for general practice in the 2024/25 contract discussions – managing increasing demand, retaining the current workforce, improving financial sustainability and aligning to system priorities – while setting out the longer-term ambition for future contracts aligned to the ambitions set out in the Fuller stocktake.

Any future reform, including through national contracts, needs to recognise the value of investing in primary care, including the GP partnership model described as 'innovative and efficient' by the Health and Social Care Select Committee. Historical underinvestment needs to be remedied, with funding that should follow the required shift in patient activity out of hospital towards a more preventative approach to care.

A report by the NHS Confederation and Carnall Farrar analysed the influence of NHS spending on economic growth; this report analysed gross value added (GVA) relevant to areas of local health spending. The report cited a GVA of £14.14 for every £1 spent in primary care. Investing an additional £1 billion (less than 1 per cent of the national budget) in primary and community care would benefit the national economy by over £14 billion.

In establishing our priorities, we recognised the need to preserve the fundamental core elements of general practice, while building a

sustainable infrastructure and delivery model for the future – harnessing the best of technology, collaboration and partnership working.

Our overall long-term vision is for simplified, clear, cohesive national contracts for practices and PCNs that ensure patients can receive an equitable level of care irrespective of where they live, at the same time as enabling greater local commissioning and provision based on the needs of the local population and individuals. This approach could lead to the alignment of national contracts, health inequalities funding and local incentives to deliver for patients according to their specific needs, promote innovation and service development at scale. This long-term vision would require core funding protection with a Primary Care Investment Standard.

The following sections in this report were guided by our vision for the future of primary care. A primary care system that is empowered, connected and respected:

- **An empowered, sustainable primary care system** – with agency to influence and innovate through parity of investment in capacity, leadership and research.

- **Citizens as partners** – engaged in service design and equipped with the information and technology needed to self-manage their health and wellbeing.

- **Delivery of the right care, in the right place** – a primary care landscape that acknowledges and embraces different models and scales to drive sustainability and enable transformation, innovation and improvement.

- **A commitment to access, continuity and personalised care with a focus on reducing health inequalities** – moving away from siloed and competitive activity-led work to impact-led interactions.

- **Care provided by a connected, skilled and respected workforce** – with teams of teams in an integrated neighbourhood at the forefront.

- **Genuine commitment to primary care at scale as a key part of population health management and quality improvement** – better outcomes for people, communities and staff.

We believe that while the 2024/25 contract provides a ‘stepping stone’ year it is important to describe the high-level objectives (such as those above) that set out the intentions for the longer-term contract discussions and provide the criteria against which to assess the compatibility of any future proposals.

We also believe that there is an opportunity to adopt a ‘pathfinder’ approach so that those PCNs that can demonstrate a level of maturity and innovation (agreed with their integrated care board) could be afforded additional freedoms and flexibilities during 2024/25 to test out new approaches that support the longer-term objectives. Ultimately, PCNs should be commissioned to define the needs of their local population, design the services and workforce that meet those needs and deliver those services against a set of agreed outcomes.

Methodology

Between June and August 2023, we conducted over ten engagement sessions, involving over 250 primary care leaders, through its Design Groups and wider primary care membership focused on the future GP contract and PCN DES for 2024/25 and beyond. (Design Groups have core representation from across the NHS Confederation's membership of PCNs, GP federations, NHS trusts and integrated care systems (ICSs) supported by communities of interest).

We also collected member feedback via surveys, focus groups and case studies. The engagement focused on existing challenges, contractual blockers, enablers and solutions.

In August, we tested our emerging thinking through a series of member sessions focused on access, workforce and estates, data and digital, integrated neighbourhood teams (INTs) and incentives (IIF and QOF). NHS England and the Department of Health and Social Care were invited to observe the conversations. These member sessions allowed for stress-testing of the pre-developed priorities while allowing for valuable local insight into the tangible contractual and non-contractual changes that would support primary care leaders, enabling innovation and constructive change.

Our immediate priorities are designed to be practical and realistic, appreciating the existing pressures as well as funding and workforce limitations. We have also highlighted key areas that need further

development, discussion and research over the next 12 months in the context of longer-term objectives for the future of primary care. The NHS Confederation supports further rapid development of primary care policy working in partnership with members, national bodies, patient groups and others ahead of discussions for 2025/26 and beyond.

An empowered, sustainable primary care system

The future sustainability of primary care will depend on its ability to make a positive impact on workload, workforce and infrastructure challenges, as well as the ability to transform to meet the changing needs of patients and the growth in the use of technology. At-scale infrastructures can create some levels of resilience but significantly increased workload without the capacity to match, combined with constraints on funding is putting practices, PCNs and federations across the country at risk. We need to make significant inroads across these key areas if we are to move from primary care simply surviving to thriving within integrated care systems.

Existing investment levels are no longer adequate to serve the changing health needs of our populations and the evolving role of general practice. The current funding formulas fail to adequately account for deprivation, which contributes towards inequitable funding across general practice. If we are to truly harness the role of general practice in tackling health inequalities and improving population health, fairer funding, based on need will be at the core of getting this right. The ‘stop-start’ nature of incremental resource undermines primary care’s ability to plan and deliver, making investment decisions difficult.

With increasing demand and workforce, the physical space to consult and see patients is also becoming inadequate. The lack of space is one side of the coin but the repair bill for primary care estates is another huge challenge. As stated in the Fuller stocktake, there is an opportunity to undertake a wholesale review of the primary care estate, working with health and care partners to maximise opportunities for co-location.

There are varying levels of digital maturity across primary care. Short-term funding arrangements hamper the ability to integrate, collaborate and innovate and General Practice Access Data (GPAD) does not truly reflect demand, pressure, and activity across the board. Now, more than ever, a sustainable primary care system requires robust data and digital capabilities to deliver care effectively, tailor services to the needs of patients and inform future service redesign.

Alongside this day-to-day pressure, primary care is increasingly being asked to take a more leading role in the future of integrated care systems. While this will be critical to ICSs' success, any leadership role needs to be matched with resource and trust.

We know from our delivery of PCN leadership programmes that there are opportunities to build strong leadership capability and capacity in primary care in order to play an integral role alongside other system partners to build cultivating / trusting relationships and take primary care to a new level within the system.

The Primary Care Network Directed Enhanced Service (PCN DES) needs to offer stability and commitment to the existing PCN model long term, with specific recognition for the growing leadership role PCNs are expected to play to integrate at all levels. This should come alongside early communication regarding any possible devolution of commissioning from 2024/25 onwards.

Priorities

Short-term asks

- Explore proven delivery models that will improve practice resilience and sustainability, enabling a mixed economy that continues to support access to services for patients.

- Explore new legal structures, such as limited liability partnerships, to hold GMS and PMS contracts and limit GP partner liability helping to modernise the partnership offer.

- Both the GMS and PCN contracts should rise annually with a new pay uplift clause. This clause should account for Pay Review Body (PRB), Doctors and Dentists Review Body (DDRB) recommendations and wider changes to NHS pay including on-costs.

Issues that require further consideration, development and conversation with stakeholders over the next 12 months:

- Creation of a Primary Care Investment Standard, as seen in mental health, that enables a move towards a high-trust model of primary care commissioning and delivery tailored to local needs.

- Review the current primary care estates programme – specifically the HBN-11 Guidance that is no longer fit for purpose in respect of new ways of working.

- DHSC should consider the impact on primary care services of the Levelling up and Regeneration Bill, ensuring levies on future developments adequately account for primary care estate's needs.

- National review of the funding formulas for primary care to reduce disparity in funding across the country and ensure future models adequately reflect health inequalities.

Citizens as partners

Empowering patients was one of the four key pillars of the recent primary care access recovery plan and offered an important step forward in bringing primary care and patients closer together. Shifting the relationship so citizens can help to co-create solutions to current health and care challenges and manage their own health and wellbeing is essential to delivering the best outcomes for the population.

Patients should not be passive recipients of care, but supported to make informed decisions through education, technology and strengths-based approaches to care delivery. Self-management is becoming more and more part of people's everyday lives through wearable technology, health-focused apps, virtual wards and other innovations and our recent report found that people are happy to use health technology to avoid going into hospital. Citizens have greater control of their health, which should help improve the partnership between health professionals and patients and offers greater clinical capacity to provide more complex care.

Key to this is bridging the increasing gap between communities and health professionals, but we must not underestimate the significant amount of time, capacity and capabilities that meaningful community engagement needs. Capacity and capability pressures in some areas has resulted in a strain in the relationship in between general practice and patients. We are seeing more pressure on the 8am rush,

increased failure demand, people feeling ‘bounced’ between different services and decreasing patient satisfaction ratings. For this to improve there needs to be increased commitment at all levels to better communicate and work with citizens to enable them to receive the care they need when they need it and to design future services that meet the needs of people.

This should not be about reinventing the wheel or building new national incentives but should focus on optimising existing opportunities to engage; drawing on, and supporting, leaders and organisations working in/with general practice who truly have brought citizens and practices closer together, and giving the time and freedom within primary care to build approaches that add value through a staged approach.

Patient participation as set out in the GMS contract requires practices to set up a group to obtain the views of patients who have attended the practice and enable the practice to obtain feedback from its registered patients about those services. Where these are working well, practices have tailored their approach to what works for patients and the practice, maximising the interactions with citizens.

We believe this is an important part of the GMS contract and should remain, but practices should be encouraged and supported to explore new ways of evolving their existing approach to patient participation, incorporating wider engagement across the PCN and at-scale providers to bring expertise from across the community, including the voluntary and community sector and local authorities.

Priorities

Short-term asks

- We support the plan to deliver a national communications campaign and would encourage support being made available to ICBs to build on this at a local level to ensure patients understand how to access the most appropriate service or clinician for their needs.

- National patient representative bodies should work with primary care providers to co-create packages of support that can be locally tailored to improve demographic data, citizen engagement and communication for patients with diverse needs.

Issues that require further consideration, development and conversation with stakeholders over the next 12 months:

- NHS England, system leaders and provider collaboratives should explore how the workforce can better align to a neighbourhood and place footprint, so person-centred care becomes a collective responsibility.

Delivering the right care, in the right place

The nature of our population and the differing structures of health and care organisations means there is unlikely to be a single organisational form that best delivers the core functions and values of primary care. System flexibility should be offered to allow new models while protecting what is already working well.

We continue to support the valuable role of the partnership model where it is working well, but more needs to be done to allow for the flexibility of an evolving primary care landscape that creates infrastructures that work for that local area. In many cases, at-scale primary care will have the ability to deliver a range of services more efficiently and effectively and to simplify and integrate within an often complex health provider landscape through innovation, transformation and improvement, supporting a shift towards upstream preventative care and activity out of hospitals.

Local innovation and flexibility are key in delivering services that meet the needs of communities. Currently patients are navigating a complex system of multiple providers for their acute and chronic conditions. There is a need to streamline the national asks of primary care and allow local leaders to determine the services needed to address the needs of their local population and the workforce they require to deliver them. This new approach should enable local integration and collaboration, with systems working with providers to

make the patient journey cohesive at neighbourhood, place and system.

Priorities

Short-term asks

- National primary care contracts should be streamlined, retaining a core national focus on areas of high impact. Streamlined national contracts should provide continuity and assurance to providers with a clear, concise long-term vision.

- To increase local flexibility and encourage innovation, a national 'Pathfinder' programme should be developed for those PCNs that can demonstrate a level of maturity and innovation (agreed with their ICB). This programme should allow additional freedoms and flexibilities during 2024/5 to test out new approaches both within primary care and the wider system. The pathfinder programme could be extended to PCN alliances or GP federations where the ICB agrees the opportunities that exist for wider at-scale testing.

Issues that require further consideration, development and conversation with stakeholders over the next 12 months:

- Future funding should flow directly into streamlined national contracts and local incentive schemes, allowing systems to commission and design services based on local needs, driving resource into preventative and curative primary and community-based care.

- Review of (primary) urgent care needs and consideration given to the opportunities to streamline and integrate current delivery

models that span primary care, NHS 111 (call handling and clinical assessment), GP out of hours and urgent care services.

A commitment to access, continuity and personalised care with a focus on health inequalities

Primary care must be able to offer equity of access to the full range of services – whether these are preventative, proactive or reactive care models. Where this is done well primary care has come together with other system partners to deliver timely access to care through providing personalised, continuity of care that addresses the drivers of ill health.

The challenge is, alongside capacity and funding constraints already included in this paper, there are also significant barriers that prevent integration across primary care and between primary care and other system partners. This creates siloed, competitive activity-led approaches rather than outcome-based impact-led interactions. NHS leaders have identified key levers that the upcoming major conditions strategy can use to maximise its impact on healthy life expectancy and reduce inequalities. These fall under three categories: create a healthy society; make the most of existing infrastructure and policy; and implementation.

The Fuller stocktake provided several actions that would enable a ‘one system’ approach to enable better integration, including requiring systems to develop a ‘one-estate’ approach, optimising co-location where appropriate and supporting integrated neighbourhood teams. Alongside these further action needs to be taken at a national level.

Our members also told us that the current incentive regime is overly bureaucratic and lacks a local focus. The current incentives in both contracts focus largely on access but fail to acknowledge the benefits of continuity of care and primary and secondary prevention as fundamental elements of general practice. The lack of application programming interface (API) between providers is detrimental to continuity of care across the NHS. Our members have articulated their desire for the incentives to focus on areas of high impact while increasing the flexibility in attainment of the incentives. It is important that contractual incentives recognise the fundamental aspects of general practice while rewarding and recognising innovative new approaches to deliver care.

Our members recognise the need to consolidate the existing incentive regime to focus on areas of high impact to reduce health inequalities nationally. This national approach of consolidation should be followed with increased local incentives, programmes and funding for systems to bring organisations together around the CORE20PLUS5 to focus on local needs and inequalities at neighbourhood, place and system.

Priorities

Short-term asks

- The Quality Outcomes Framework (QOF) and the Impact Investment Fund (IIF) should be streamlined to focus on high-impact areas and true outcome-based measures while protecting primary care funding.

- Delivery of QOF should recognise new ways of working to achieve outcomes, for example group consultations (where appropriate) in patients with long-term conditions.

- Consolidate the quality improvement (QI) elements of QOF and create a quality-improvement incentive within the PCN DES focused on continuity of care. This approach should encourage PCNs to work collaboratively to improve continuity of care across their practices.

- Review the QOF markers for vaccinations and immunisations to reflect the challenges associated with different groups of the population. This approach should facilitate a more flexible delivery approach and collaboration with partners while securing existing GP provision.

Issues that require further consideration, development and conversation with stakeholders over the next 12 months:

- Standardise digital interfaces between primary and secondary care, primary care and community pharmacy through nationally mandated interface standards and prioritisation of API integration between clinical systems.

- Use health inequalities (HI) funding to enable a system-led approach to prevention, bringing together HI leads from different organisations to focus on CORE20PLUS5 and local system priorities.

Care provided by a connected, skilled, and respected workforce

Dwindling numbers of GPs (and practices) are a significant threat to being able to deliver even the basic requirements of timely access to services and high-quality patient care, with Health Foundation research forecasting one in four posts will be vacant by 2030/31. We should not underestimate the impact this will have across the whole health and care system. GPs are being asked to take on a multitude of new leadership roles, creating additional demand on their time and increasing burnout across the sector.

Investing in the whole primary care workforce and recognising its contribution as a key partner in delivering integrated care is vital in realising both the short-term and long-term ambitions of the health and care system.

The Additional Roles Reimbursement Scheme (ARRS), bringing over 20,000 new roles into primary care, has meant new skills and team approaches to care deliver. To further help with retention, capacity and capabilities locally and ensure this scheme continues to succeed, PCNs need increased flexibility to determine their workforce needs within the funding available.

Equally important is the role of primary care leadership for the future of integrated health and care, ensuring existing and aspiring leaders in primary care have access to leadership development opportunities across the system. A focus on developing multi-professional leadership at all levels through education, training and development for clinical and non-clinical staff, will be core to primary care being able to drive local health improvements, as outlined in the Messenger review. We know there is significant variation in leadership capabilities across the country acting a large factor in the maturity of the primary care system and organisations within. Therefore, implementing the leadership and management training standards recommendations set out in the Messenger review will be key to bridging this gap.

Looking beyond the current day-to-day challenges, if we are to truly tackle health inequalities and improve the health of our population we need far greater alignment of the health and care workforce towards communities. For many across the country, this feels a long way off and, without a commitment to this direction at a national level, it becomes even more difficult to prioritise. Moving towards integrated neighbourhood approaches requires a commitment at all levels to a different approach and greater flexibility for the local workforce needs to be determined by those working and delivering in that area. A strong PCN workforce will be a key part of that workforce as a consistent source of trust, local knowledge, leadership and care delivery, but they cannot do this without other partners. For this to truly work we need full realignment to community-focused care driven by the system, rather than one part of the system.

Priorities

Short-term asks

- Greater flexibility in the use of ARRS funding to allow for local determination of the skill-mix required, with training and supervision, to meet the needs of the local population and make primary care a more attractive place to work.

- Increase the flexibility of GP recruitment and retention schemes. To create a comprehensive career pathway, while accounting for local need such as deprivation and health inequalities.

- Increase investment in the management and leadership infrastructure of PCNs, and wider primary care leaders, to continue to build strong leadership capability within primary care and place it on a firm footing with the rest of the system.

- Agree a set of high-level principles for integrated neighbourhood working that recognises the contribution of each sector. These will underpin their commitment to the approach and shared understanding of roles and responsibilities, including the PCN workforce as part of integrated neighbourhood teams.

Issues that require further consideration, development and conversation with stakeholders over the next 12 months:

- Further work is required to align primary care workforce contracts and funding to the rest of the NHS to ensure that primary care remains equipped to support a greater shift of activity and funding into the community.

Genuine commitment to primary care at scale as a key part of population health management and quality improvement

We continue to advocate and support at-scale infrastructures that can support the delivery of services while providing expertise on HR, governance, communication and finance. Through our membership we have seen the huge opportunities for at-scale providers such as PCN alliances, GP federations and provider collaboratives to not only help sustain general practice and support PCNs, but to contribute to demand management and more efficient delivery of care in the wider system.

At-scale organisations and models play a vital role in integrating primary care with other providers and supporting integrated working that improves personalisation, continuity, access and upstream provision of health and care. When resourced with the fit-for-purpose digital software, expertise and capacity, at-scale primary care can be a source of local insight vital to improving population health and improving care.

Primary care providers across the country have undertaken large-scale digital transformation and are developing comprehensive new

datasets to better understand their community of patients through segmentation and risk stratification. It is vital that this understanding and knowledge within primary care is considered when developing new national, regional and system datasets for population health management. Our members are keen to contribute their ideas and thoughts in the development of new digital frameworks that are more competitive, allowing new innovative entrants to market.

Priorities

Short-term asks

- Investment in primary care provider collaboratives to support the development of a collective voice for primary care at ‘place’ and opportunities for service delivery at scale.

- Amend national guidance on provider collaboratives to promote and encourage primary care involvement, where appropriate.

- Sufficient time should be provided to primary care providers to develop new comprehensive datasets, acknowledging the range of digital maturity across the country.

Issues that require further consideration, development and conversation with stakeholders over the next 12 months:

- Engage with PCN digital and transformation leads when reviewing suppliers as part of the national frameworks to ensure a fit-for-purpose supplier market now and in the future.

- Systems should support primary care in building a high-quality dataset through a population health management approach to

develop personalised and preventative models of care at neighbourhood, place and system. This integrated dataset should use new technology and data from local and national sources, such as cloud-based telephony, triage tools and the ONS Health Index.

- Future updates to frameworks should enable quality competition across the board, from the electronic health record to telephony. Ensure there is a clear and timely route for innovators and competitors to enter the market via certified national frameworks.

- The role of ‘at-scale’ providers should be recognised in the delivery of innovative approaches to supporting integration and driving improvement in population health management. The opportunity to take part in ‘pathfinder’ programmes should be available to them.

Viewpoint

This report has presented the feedback and priorities of members after a series of engagement sessions on the future of general practice and primary care. The pressure and overall demand on general practice is set to continue for some time. We should not underestimate the value of general practice in supporting the needs of our communities and managing the impact on the rest of the system. In our work with PCNs, we have seen the value of at-scale infrastructure, through the PCN or around the PCN through GP federations and PCN alliances.

This report has focused on tangible priorities that can address some of the immediate pressures facing general practice and PCNs across the country. As the centre continues to delegate responsibility to integrated care systems, and the primary care landscape continues to change, we need to maintain a national minimum standard of what is expected of general practice, along with greater local flexibility for ICS and primary care leaders to commission local services that deliver their local vision and priorities.

A modern approach to general practice is required – protecting the best of what works well while acknowledging that there are challenges (workforce and funding) and opportunities (patient behaviours and technological advancements) that will require different solutions for the future. These solutions need to be driven locally, operating within a national framework but with local

commissioning to design outcome measures and incentives that align to local priorities and needs.

Our engagement brought together primary care solutions-focused leaders who are passionate about making things better for their local population. As a network we firmly believe the answers and solutions to some of the biggest challenges we are facing exist within. We welcome further engagement from national and system leaders as we continue to discuss the priorities for the future over the next 12 to 18 months.

This report is published on behalf of the Primary Care Network leadership and Design Group chairs.

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- Michael Smith, Vice-Chair, Primary Care Network
- Dr Dan Bunstone, Chair, Digital and Data Design Group
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