Long-term plan must allow time for primary care networks to develop

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The NHS Long Term Plan was launched last week at an event attended by the prime minister and NHS England chief executive Simon Stevens.

The 134 page plan covers a wider range of themes. The headlines are summarised below along with emphasis on the implications for commissioners and providers of primary care services.

General

In the wake of the NHS's 70th birthday, the dominant theme for the plan is long-term sustainability and the measures the NHS will need to take to reach its 80th birthday in good shape.

Inevitably that means much of the plan focuses on the need for the NHS to live within its means, to continue to make gains in productivity (which is improving at a faster rate than in the private sector) and to reduce deficits in secondary care.

The 30 worst performing trusts will be given more assistance by NHS Improvement in the form of an "accelerated turnaround programme", but the plan acknowledges that longer term solutions to the resources issue are required.

There will be a renewed focus on out-of-hospital care with more money for primary and community care, and on prevention and healthy living programmes to reduce the burden of ill-health and disease across the NHS as a whole.

Spending on primary and community care will for the first time grow faster than the NHS budget as a whole creating "a ringfenced local fund worth at least an extra £4.5bn a year in real terms by 2023/24", though as an HSJ analysis makes clear the baseline for funding is currently unclear.

There will be a strong focus on "digitally enabled healthcare" reflecting the health and social care secretary's enthusiasm for this topic, but also driven by wider recognition that NHS IT remains outdated and poorly interconnected.

IT enabled self-care applications and virtual consultations to replace face-to-face appointments in primary care and outpatient clinics are seen as making a big contribution to efficiency as well as meeting growing consumer expectations for convenience and easier access to services of all kinds.

The plan also acknowledges that workforce remains the biggest single existential issue for the NHS. While it outlines a number of initiatives to improve the morale of existing staff and to attract new staff to fill the gaps in the clinical workforce, the plan largely defers to Health Education England whose workforce plan is due later this year.

Integrated care and commissioning

The long-term plan states that integrated care systems (ICS) will cover all England within two years. This has profound implications for the existing commissioning system and amounts to de facto structural reform. Each ICS will "typically" be based on one CCG, the plan says. As there are currently 44 sustainability and transformation partnerships (STPs) - the virtual organisations from which ICSs will be born - and 195 CCGs, expect to see rapid rationalisation of CCGs over the next two years as commissioning plays its part in the plan's promise to "save taxpayers a further £700 million in reduced administrative costs across providers and commissioners".

While a single commissioner for each ICS area is logical, the change process will mean some loss of jobs, the potential for disruption of local plans and relationships, and loss of capable experienced people as well as organisational memory.

Other aspects of the reframing of the commissioning system around ICS may require changes to the law. For example, "legal shared duties" between commissioners and providers are likely to need a more robust legal framework than is provided by the 2012 act. Lack of accountability and the need to rely of coalitions of the willing is widely seen as a fundamental weakness of STPs.

The plan also signals necessary changes to the competition and procurement aspects of the Lansley act, which have long been considered antithetical to integrated care systems and which add cost, complexity and risk to commissioning.

Commissioners and others in ICSs should welcome the news that a single accountability and performance framework will replace the existing patchwork of local accountability arrangements.

The new and simplified framework will include an "integration index" to measure "the extent to which the local health service and its partners are genuinely providing joined up, personalised and anticipatory care", though the plan provides scant details about how this might work in practice.

Primary care networks

If the plan's focus on primary care networks comes as no surprise, the pace of development is, to say the least, ambitious. National bodies expect all GP practices to be members of a network by April this year, which suggests that initially they will be networks in name only.

Primary care networks have two functions in the vision set out by the plan. Practically they provide the local delivery units that will form "building blocks" of ICSs. But they also provide the mechanism by which to realise the vision "for the first time since the NHS was set up in 1948 – of fully integrated community-based health care."

Each network will provide not just the necessary scale (the familiar 30,000-50,000 population base) but a single contractual entity: an employer for multidisciplinary teams that in some of today's more loosely configured networks depend too heavily on goodwill to be sustainable.

The carrot or stick for bringing GP practices into PCNs is the network contract, a single contract with the PCN to allow services that the members of PCNs will deliver between them to be funded. The network contract is in the final stages of agreement with the BMA's General Practitioners Committee (GPC), so the detail remains to be seen.

The principle is clear, however. While core GMS contracts are to remain in place for individual practices, the opportunities for additional income, including enhanced services and QOF (which is to be replaced by a new quality payments scheme), will from now on be channelled through a shared contract.

Among the many unanswered questions:

How will the new arrangements work for existing practice networks, federations and super-practices? Some of these already cover much larger populations than 30,000-50,000 and are not geographically coterminous. Others have already formed local networks that push them over the 30,000 threshold and developed working relationships with partners of choice.

Some of these are already under pressure from CCGs to widen their networks, usually on the basis of geography, to bring weaker practices into their networks. GPs worry that successful working relationships could be destabilised if commissioners attempt to influence the make-up of their networks. This threat significantly increases when CCG are obliged to find network homes for all their practices.

How willing will individual practices and GP partners be to enter into arrangements where enhanced services funding has to be pooled and shared with others?

What will the long-term impact be on the existing contract? The intention appears to be to reduce core GMS payments as a proportion of practice earnings, using the network payments to incentivise collaboration – fine in theory but fraught with problems in practice. Some GPs are already talking about GMS being "starved of oxygen" leaving them to make up lost income in the unknown territory of the network contract.

These anxieties appear strongest among existing GP partners and particularly those that have already made early moves to build their practices through relationships with other local providers, expanding their teams to include clinical pharmacists, paramedics, mental health specialists and other professionals, and starting to work more closely with social care and the voluntary sector.

The clear danger is that in trying to construct a uniform approach designed to bring the laggards on board, commissioners could be at risk of alienating the first movers, those already converted to the cause of primary care at scale.

The long-term plan suggests that there will be a new "duty to collaborate" – a worrying phrase that misses the point about what is likely to make collaboration successful: good relationships built on trust, mutual interest and a desire to do a better job for patients.

Today an estimated 30% of practices are in some form of network, but they vary widely in form. The hope that all practices will be networked by April is optimistic, particularly when many currently may not understand the purpose of primary care networks, may need convincing of the need to be part of one, will almost certainly need reassuring about the implications and may need support to work out how best to go about it.

Conclusion

Primary care has every reason to welcome the NHS Long Term Plan for its promise of extra funding, and for its recognition of the crucial role of primary care in creating truly joined-up local services. However in the execution of the plan, the NHS needs to take care not to extinguish the flickering beacons of good practice that have been lit in the past few years. National bodies and some commissioners may need a gentle reminder that it's not called a long-term plan for nothing. There is no doubt that primary care needs to happen "at scale", but it's unlikely to happen at once.