

REALISING THE NEIGHBOURHOOD NHS DELIVERING A NEW DEAL FOR PRIMARY CARE IN ENGLAND

Chris Thomas and Harry Quilter-Pinner | February 2020

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SUMMARY

General practice is the ‘jewel in the crown’ of the NHS. For most of us the GP is our first point of contact when we are unwell, the gatekeeper to treatment we might need and the only healthcare professional we build an ongoing relationship with over our lifetime ‘from cradle to grave’. A strong primary care sector – including teams of nurses, pharmacists, mental health specialists and allied professionals – has been shown to deliver better health outcomes, a decrease in utilisation of hospitals and emergency departments (Macinko 2003) as well as slower growth in health care spending (Kringos et al 2013).

But, in England, general practice also needs fundamental change. This is evidenced by four main factors.

- **Quality:** Quality in primary care remains stable with 95 per cent rated good or outstanding by CQC and high ratings in the GP Patient Survey. But these overarching quality metrics hide significant variation in the quality of care for specific conditions (for example diabetes and cancer diagnosis) that need to be addressed.
- **Access:** Access in primary care is poor. New polling conducted for IPPR shows that 36 per cent of people in England waited more than a week for an appointment, and 3 per cent were not able to book an appointment at all, the last time they needed one. Furthermore, access is even slower if you have been diagnosed with a long-term condition.
- **Demographics:** The country’s population is growing, ageing, and living with more complicated health needs. Notably, people are growing older but are living more of their life in ill-health. Their illnesses are increasingly chronic rather than acute, including diabetes, mental illness, frailty and dementia. This shift in the disease burden demands a fundamentally different model of care.
- **Workforce:** The workload of GPs has been increasing as a result of increased bureaucracy, growing patient complexity and increases in medical knowledge. Across the sector there is evidence of increased stress, burnout and mental ill-health in the profession. This is leading to a GP shortage and a workforce crisis.

There is a growing consensus that a shift towards primary care at scale - what we call the ‘neighbourhood NHS’ - is the solution to these problems. Most primary care is still delivered by GPs in small independent practices. While this has some advantages, it also limits the scope of care general practice is able to provide. The alternative is primary care at scale (between 50,000 and 100,000 people). Under this model, as a result of economies of scale, it is cost effective to invest in longer opening hours, diagnostics and treatment in the community, and a wider team of healthcare professionals to support the GP in delivering integrated care. There is growing evidence this delivers higher quality care as well as improving access and relieving workforce pressures on the GP.

Recent government reform initiatives have made some progress in delivering on this vision. The NHS *Five Year Forward View* set out a vision for greater collaboration between general practices, as well as with community health services, hospitals and social care. This has been further developed in the NHS *Long-Term Plan* which announced the intention to formalise these new arrangements in the form of primary care networks (PCNs) (NHS England 2019). These are new groupings of local general practices that are a mechanism for sharing staff and collaborating while maintaining the independence of individual practices. There are now 1,300 PCNs in England with more than 99 per cent of local GP practices signed up to the initiative. On the face of it this would appear to be an impressive record.

But the evidence suggests that there is much further to go. While partnerships between practices might be common, they are not particularly deep. A recent study found that the proportion of general practices “working closely at scale for the purposes of core general practice, with shared strategy and risk” to be less than 5 per cent (Forbes et al 2019). This means many people (around 50 per cent (ibid)) are served by primary care services that have not fully developed the scale of their organisation and service delivery, with many more lagging even further behind. This is concerning. There is evidence that single organisations – or tighter partnerships – may be preferable to networks for the delivery of coordinated care (Sheaff et al 2015). This suggests PCNs need to quickly move beyond loose networks or federations towards single integrated organisations.

The biggest barrier to delivering the ‘neighbourhood NHS’ in England is the partnership model and the GMS contract. GPs are primarily funded through core national contracts called the GMS for delivery of essential services (see figure 2.6). GMS funding is made up of the global sum (capitated payments) based on the age and gender of patients and other factors. Partners fund their costs through this and keep any excess as profits. These contracts therefore create what we call the ‘inverse pay law’: those GPs that are the most efficient and deliver the most basic care keep the most profit. This limits the incentive for GPs to innovate and expand provision. Recent initiatives to overcome these incentives, such as PCNs which provide additional funding to federations, are a step in the right direction but ultimately protect a failing model.

We need a ‘new deal’ for general practice to overcome these challenges. We argue this should be made up of four main components across England.

- **Create neighbourhood care providers (NCPs) to deliver the ‘neighbourhood NHS’.** A ‘new deal’ for general practice would recognise that the best way to work together as a team is to work together *in* a single team. We recommend that PCNs should move away from loose federations and instead practices should come together in new integrated trusts to provide primary, community and mental health care in a local area. They should also deliver relevant social care and public health services, in order to really fulfil the possibility of population health.
- **Offer all GPs the right to NHS employment.** Senior general practitioners (both partners and salaried employees) should be recruited into management roles within the new NCPs (on similar salary levels to a current GP partner) alongside other non-clinical senior managers. All newly qualified GPs should also be offered a salaried role within the NHS. This builds on the existing trends away from the partnership model and is popular with the public: our polling shows that four times as many people support GPs being employed by the NHS than as partners.
- **Reform new GP roles to create career progression, time to care and realistic workload.** Workload should be reduced by moving away from a nine-session week towards seven clinical sessions per week for full time staff. The time freed up by this should be used for career development, respite and developing other specialisms such as management, academia or specific types of care (including end of life care and mental health). Finally, GPs should be given time to care by moving to 15-minute sessions for people with long-term conditions. More action will be needed to promote automation, team based primary care and patient self-management in order to reduce demand for new GPs as a result of these changes.
- **A radical transformation of the primary care infrastructure.** The primary care estate is often privately owned by GPs and unfit for purpose as a result of underinvestment. This is a barrier to delivering the ‘neighbourhood NHS’. The government should commit to funding and building 1,300 new primary care hubs (one per PCN) and invest in new technology. This should be funded by state borrowing – and would be cheaper than existing funding mechanisms such as PFI.

The progressive policy think tank

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Institute for Public Policy Research

IPPR, 14 Buckingham Street, London WC2N 6DF | www.IPPR.org | [@IPPR](https://twitter.com/IPPR)

