BMA

England

General practice and integration: Becoming architects of new care models in England – A paper for discussion

April 2015

General practice and integration (England)

General practice and integration: Becoming architects of new care models in England – A paper for discussion

INTRODUCTION

The Five Year Forward View (5YFV) of October 2014 set out several new care models designed to 'dissolve traditional boundaries' between general practice, community services, hospitals and social care. Vanguard sites have now been selected to test these new models of integration, though movement towards more integrated care is already well underway in many parts of England. This was demonstrated by the large number of applications for vanguard site status from providers and commissioners already engaged in integration work, including some organisationally ambitious projects.

This discussion paper has been prepared by the BMA's General Practitioners Committee (GPC) for Local Medical Committees. It aims to stimulate discussion and support LMCs' role in advising GPs on the various models of primary and integrated care emerging across the country. The BMA is undertaking an extensive programme of work in relation to the Five Year Forward View. This includes a number of briefings for members on the new integrated care models, the evidence behind them and the payment systems that will enable them, such as capitated budgets. The briefings will be available on the BMA website in due course.

The 5YFV reflects and promotes a new pace of change in the dissolution of organisational boundaries. Regardless of the outcome of the general election, policy movement towards more integrated models of working is now inevitable and it is a question of *how* not *if* sectors of health (and social) care collaborate, reorganise and become subject to new commissioning arrangements. The 5YFV is an NHS document and now needs both professional leadership and real 'grass roots' buy-in to be translated into reality.

The BMA's General Practitioners Committee welcomes initiatives to reduce service fragmentation and align organisational interests for the benefit of patients through the development of collaborative working. The current arrangements of competing providers and, at times, rigid separation between general practice, community providers, secondary care and social care are having a detrimental effect on patients, with disjointed service delivery, duplication, increased transaction costs and flows of funding which create perverse incentives that do not reflect patient needs.

The future of healthcare is in collaborative, holistic, clinician-led working, both across the primary and secondary care interface and ultimately across health and social care. This requires aligned incentives and organisational structures based on local population and patient needs. It is widely acknowledged that the future of the NHS also depends on moving more care, with adequate funding, into the community. This is reflected in the 5YFV's promise of a 'new deal' for general practice – an absolute prerequisite for GP engagement in the development of these models. The challenge GPs face now is creating new models of care that deliver these goals while protecting and promoting the most important organisational elements of traditional general practice, namely:

- A registered list system delivering patient-centred continuity of care
- Small-scale direct connections with local communities in the primary care setting, regardless of broader developments in health service organisation
- The continuation of a nationally negotiated core contract for essential services underpinning fair and consistent health service delivery to patients across England regardless of post-code
- General practice led by general practitioners working within broader multi-professional teams
- The freedom of GPs to be independent advocates for their patients

Improvements in patient care must always be the prime motivator for and measure of change**.**

With these fundamental principles in mind, and having accepted the general direction of travel towards more collaborative and integrated ways of working, the question becomes –

> **How might GPs want to work within, and become architects of, new integrated care models?**

This discussion paper tackles that question. After putting integrated care developments in context, it sets out some different emerging models, discussing potential implications for GPs and the development of general practice.

Some models of integrated care may develop based on close early collaborative working across organisational boundaries, for example between a community provider and local GPs. However, given the increasing trend towards GP practices working collaboratively, we suggest that formally constituted GP provider organisations, such as networks, are likely to be a good vehicle of transition from current structures towards more integrated care arrangements and among the most likely to preserve the best features of traditional general practice. If GP networks are to fulfil their potential to drive integrated care delivery, both GPs and policy makers must now focus on the formation and structure of these organisations. The paper introduces some key considerations for discussion and development.

Integration works best where all those involved in planning and delivering the care share decisions and responsibility for developing models. With that in mind, close working between GPs, consultants and others is essential where closer working between the sectors is envisaged.

PART ONE: BACKGROUND

General practice and the provider landscape

For historical, geographical and political reasons, primary, secondary, community[1] and social care are delivered in different ways across England. Differences in organisation and delivery exist across all sectors, particularly in community care. GP practice organisation also varies widely and can be:

- independent (but of widely varying size)
- loosely federated, with a variety of motivating factors including sharing back office functions and educational activities or offering a wider range of services. Federated working has been underpinned by other formal collaborative working in the past including Primary Care Groups, Practice Based Commissioning and Clinical Commissioning Groups (CCGs).
- formally networked as providers – either engaged in active provision or in a fledging 'ready' state (this paper uses the term 'network' throughout but organisations of this nature are also often referred to as federations).
- merged super-partnerships – large scale businesses operating across multiple sites within a local community
- multi-partnerships – regional and national multi-practice organisations

Whether through super-partnerships, federations or networks, there is a clear trend towards working at scale in general practice to support individual practices, deliver a wider range of services and in some cases to collaborate more effectively with other providers in integrated care initiatives. GP networks in particular have proliferated in recent years.

A brief note on why greater integration is necessary

The current care system is far from perfect, featuring fragmented commissioning, perverse financial incentives[2], unhelpful competition policy and insufficient collaboration between service providers. Across England there is considerable variation in local relationships between providers, commissioners and Area Teams and various interpretations of competition law and tendering requirements. From 1 April 2015 commissioning structures became even more diverse with the introduction of various degrees of co-commissioning.

In most areas, the overall provider and commissioning landscape is highly fragmented and consequently patients frequently experience unnecessary barriers while navigating the system. Evidence from the BMA's own surveys and from elsewhere shows that current coordination of care is poor, both across healthcare and between health and social care. Doctors and other professionals also grapple with frustrating and inefficient organisational obstacles, such as re-

[1] The range of services provided in the community is very broad and includes for example health visiting, district nursing, family support services and physiotherapy. Since the inception of the NHS, community services and GP services have been separate in scope, funding, population coverage and ownership. In 2008 PCTs were required to divest themselves of their provider role and community services were transferred to a number of different organisations including standalone Community Trusts, third sector organisations or Acute Foundation Trusts.

[2] The way care is funded is repeatedly cited as a barrier to better integrated working, particularly the national payment tariff (PbR) which can result in work being shunted between organisations and adds to the bureaucratic burdens on doctors

referrals of patients from one organisation to another. Divisions increase workload through unnecessary bureaucracy and incentives to shift work between organisations. These problems must be tackled, particularly in a financially constrained environment.

Integration initiatives are already underway across the UK. Significant progress is already being made by some commissioners and providers to improve the coordination of care in local areas through, for example, new contracting arrangements and shared patient records. The new vanguard sites build on these existing initiatives.

The Five Year Forward View and vanguard sites

The Five Year Forward View proposed creating a number of major new care models. The new care models outlined in the document included two models of care intended to redefine the relationship between primary and secondary care: Multispecialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS). The full 5YFV descriptions of MCPs and PACS can be found in Appendix 1.

It is clear that within these models there is scope for very significant variation as well as considerable overlap between the two descriptions. In fact the 5YFV reflects a movement already underway as a diverse range of integrated models are already emerging led variously by CCGs, hospital trusts, community trusts and in some cases by large GP practices or GP provider organisations. The 269 applications received by NHS England for vanguard status and the 29 sites chosen demonstrate this diversity. The scale of the projects' ambition ranges from organising a broader range of community and specialist care services around groups of GP practices to the development of fully integrated care organisations delivering a wide range of services under a capitated budget. Some of the MCP and PACS proposals are built on a broad collaboration of commissioning and provider organisations, while others have a clear lead provider around which other services will be structured. The full list of vanguard sites can be found in Appendix 2.

There is incongruity between competitive procurement policy (and law) and more collaborative working. Most new models of integrated working will have implications for commissioning practice and policy as commissioners work closely with a defined group of established providers. As the need for increased collaboration becomes increasingly important, tensions with current competitive procurement policy may ultimately need to be resolved centrally.

Any changes to current care models and organisational structures could have implications for the future of general practice, GP contracts and employment. Similar uncertainty applies to those who currently work in secondary care. As a profession, we must consider these possible implications as we look at the emerging models. The very simplified illustrative models below are intended to assist this thinking.

Working across the primary/secondary care interface

The 5YFV offers an opportunity for GPs, community and hospital doctors to work together in true partnership to improve patient care. Truly collaborative working between professionals is absolutely essential for the development of integrated services.

PART TWO: ILLUSTRATIVE NEW CARE MODELS

This section sets out some very simplified new care models to help structure consideration of the developing environment. **The models are not intended to be exhaustive and in each broad category there could be a range of behaviours and contracting arrangements**. The models outlined here could apply to a single health economy. Indeed, under the 5YFV proposals there is a very real prospect of England developing an even more diverse range of local health arrangements, at least in the short term.

For simplicity, these models focus on health care but it is clear that we must also consider the interface and potential integration with social care. Integrated models incorporating social care are already proposed in some vanguard sites and also in the radical devolved model of integrated care underway in Manchester.

The models refer to community providers. This should be taken in its widest sense to include mental health services and voluntary sector providers.

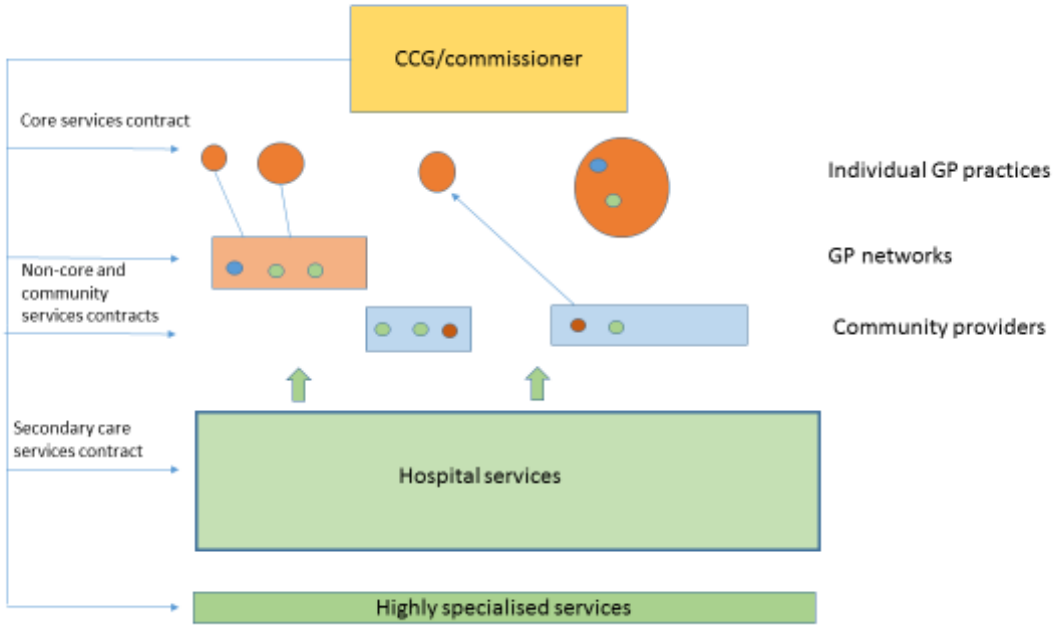
Multispecialty Community Providers (MCPs)

The 5YFV describes Multispecialty Community Providers (MCPs) as care models based on 'extended group practices' in the form of federations, networks or single organisations offering a wider range of care using a broader range of professionals. The document specifically mentions primary care employing consultants or taking them on as partners, bringing in 'senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social works and other staff… shifting the majority of outpatient consultations and ambulatory care out of hospital settings'.

The variation in current MCP models is very evident. The GPC has identified three broad types of MCP model, each of which have different implications for general practitioners and service development:

- The 'soft' MCP
- The 'directed' MCP
- MCP development through large scale GP provider networks or geographically based collaborative arrangements between GPs and other providers

'Soft' MCP model



A 'soft' MCP model

Features

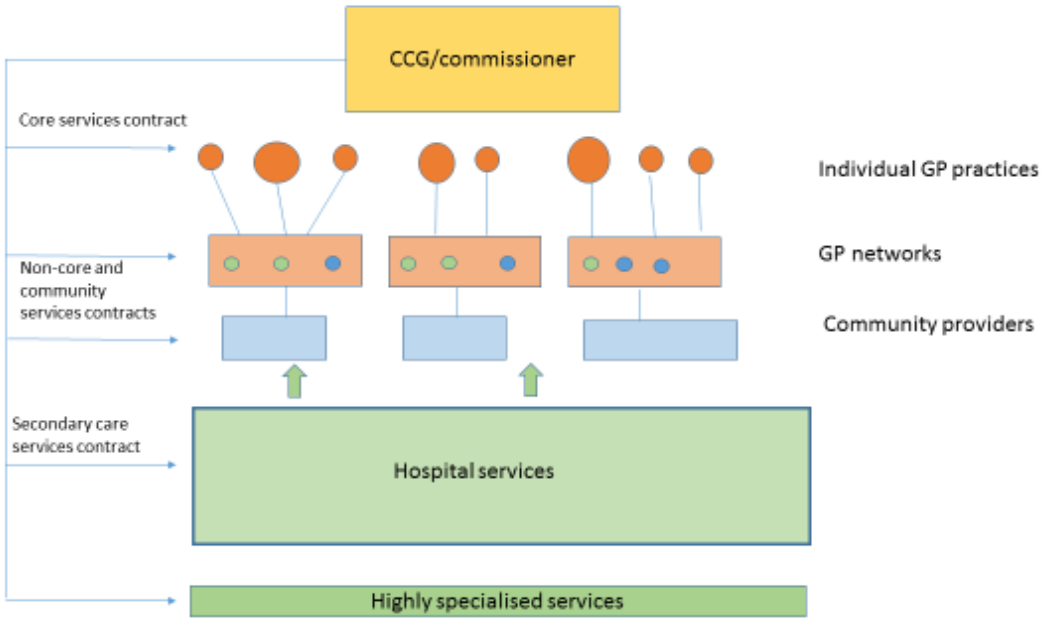
- This model is a natural and straightforward progression from the current situation in many local health economies and requires little reorganisation or contracting change. A number of local provider groups – small GP networks, super-partnerships, federations or community trusts for example - have developed quite organically and contracting ambitions for integration are modest.
- GP practices operate fairly independently but there has been some development of multiple larger provider organisations. Larger GP practices or networks/federations have the ability to engage a wider range of professionals and bid to deliver extended services to patients. Some community providers could also move into wider service provision through new contracts, partnerships with existing practices or employing GPs and specialists. Increasing integration is therefore driven largely by providers.
- The CCG contracts directly with practices but may move to more basic/core contracts over time as it increasingly contracts with GP networks and/or community provider(s) for a range of services and care pathway delivery.
    - As the 'middle ground' becomes dominated by community providers or GP provider organisations, additional and enhanced services could be vulnerable to being picked off and removed from individual practices.
    - Similarly, a certain amount of secondary care work is moved into the community, through peripatetic engagement of specialists, employment or increased collaboration between different parts of the health service.
- Heterogeneous, sometimes competing, provider groups may be welcomed as promoting choice and innovation but they also create a competitive environment which does little to

reduce inefficiency and instability and which could affect GP income and contracts over time.

- Service integration is greater than it has been in the past but still quite low across the local health economy. Hospitals remain largely unchanged as the rest of the health economy is still fairly fragmented.
- There is little prospect of this fragmented model developing into a PACS.

'Directed' MCP model

It is clear from the vanguard sites that a very different type of MCP model is being driven in some areas by commissioners. It is the purposeful and structured coordination of these developments that has led us to identify them as 'directed MCPs'. The CCG sets out to reorganise care using strong coordination and managed collaboration around newly configured units and particularly around clustered GP practices.



A 'directed' MCP model

Features

- Based around existing independent GP practices
- As now, CCGs contract separately with each practice
- Developments may initially focus on developing collaborative patient pathways through *virtual* integration. This could entail joint commissioning strategies, alliance contracting[3]/alignment of incentives or coordinated service delivery for specific populations

[3] An alliance contract is defined by the Kings Fund as "a contractual arrangement between the commissioner(s) and an alliance of parties who deliver the project or service. There is a risk share across all parties and collective ownership of opportunities and responsibilities associated with delivery of the whole

- Practices are grouped - by the commissioner - into locality provider groups eg of 100,000 patients (not ad hoc development)
- The CCG commissions community and secondary care services to support structured groups of practices. Provider organisations are more clearly aligned. This model leads to integrated working but not structural integration.
- Probably a heavy emphasis on pathway design and defined population groups.
- There is scope to move a lot of hospital services into the community based around practices as the basic unit.
- Though this is a commissioner driven model, GP practices could be satisfied with the outcome and in some cases the clustering could be based on existing clusters or fairly significant local GP engagement.
- Without a clear lead provider, it seems unlikely that this MCP type will evolve into a PACS.

NB – As members of CCGs, practices should be empowered to challenge and influence directed models.

Example vanguard site example - NHS Stockport CCG

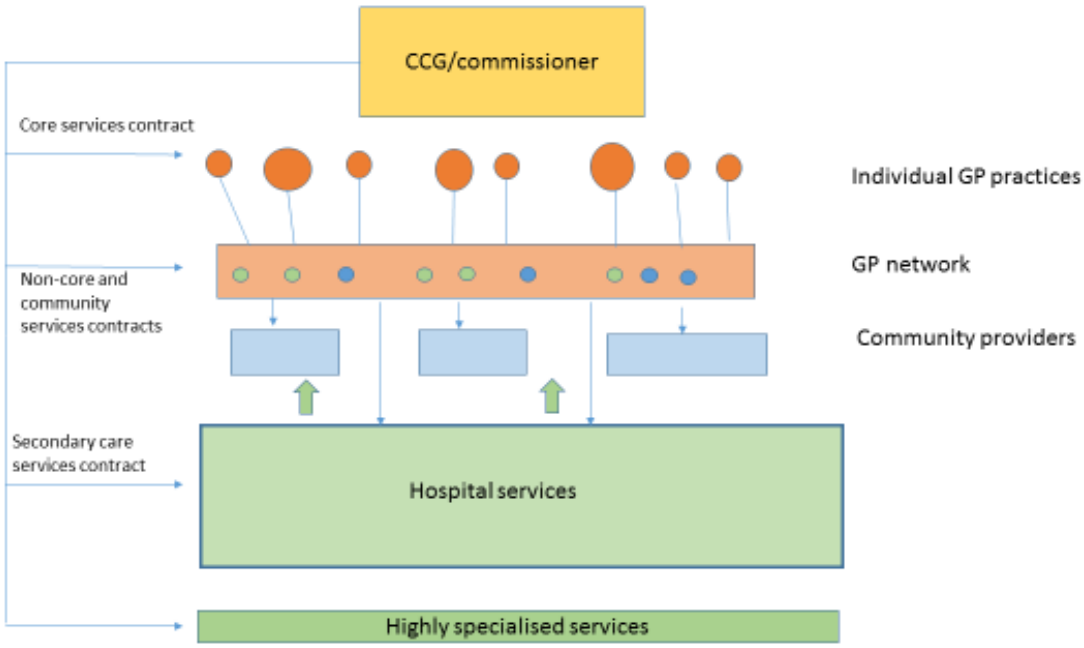
A partnership of the CCG, two Foundation Trusts and the Council intends to integrate services around GP lists at 3 different levels – neighbourhood (20-30,000), locality (70-80,000) and Borough (300,000) with a focus on for example urgent care, end of life care and shared health records.

Note: The use of these directed strategies is likely to increase even outside the vanguard areas, particularly as co-commissioning brings CCGs into primary care commissioning. It has been reported that some CCGs intend to use their new co-commissioning responsibilities to promote working at scale in primary care.

project or service. Any 'gain' or 'pain' is linked with good or poor performance overall and not to the performance of

MCP development through large scale GP provider networks

In contrast to the models above, this MCP type is much less fragmented than the soft MCP model and more provider driven than the directed model. The GP provider in this model could be a GP network, a large super-partnership or in some cases an MCP created through collaborative working between, for example, a large community provider and a large, well organised group of GPs.



MCP development through large scale GP provider network

Features of this model in the early stages of development

- Local GP practices have come together to form a large GP network (or in some cases other large scale provider organisation such as super partnerships). These networks are geographically based and ideally inclusive, democratic and probably coterminous with existing boundaries of health and social care organisations, CCGs or local authorities. The population covered is large, perhaps around 100,000 patients, enabling GPs to deliver various primary care services at scale. The MCP may be formed, not by GP organisations alone, but perhaps by formal collaboration between a large community provider and local GPs. Strong local leadership from GP providers is key.
- The GP network has a role in supporting service delivery at practice level eg providing support staff to practices and providing additional primary care services (enhanced services, extended hours, more specialised diagnostic work, some outpatient services) across a larger area.
- The CCG continues to hold core contracts with individual practices.
- The CCG contracts with the GP provider company for specific services or pathway development. The GP provider company is the prime contractor for these services but may subcontract to community providers/specialists (delegated commissioning function). The model is therefore heavily GP led.
- This is a low fragmentation, low competition model

- Multidisciplinary teams, some of whom are probably employed by the organisation, provide an increased range of services in the community, blurring traditional boundaries between primary, community and secondary care.
- As integration is still partly virtual, transactional, performance and payment systems will need to evolve to align incentives – eg alliance contracting where all contracted parties work to shared incentives and goals
- GP provider organisations may reduce the risks and responsibilities of individual practices.
- In any GP provider organisation the structure and business model will affect local GP interests. Attention to these features is therefore important from the outset.

Although this is a GP-led model, collaborative working with consultants and other professionals will be a prerequisite for successful integration.

As there is a clear lead service provider in the area, there is significant potential for development into an integrated care organisation/PACS. Over time virtual integration and care pathway management may scale-up into a more elaborately integrated model with a delegated population based budget. The provider may for example run community hospitals and have admitting rights.

Features of a mature model

- There are few competing providers in the local health economy and patients are rarely 'discharged' or moved between providers.
- Large, mature GP provider organisations could assume responsibility for all health care for a defined local population, except for the most specialised services, using delegated budgets and the registered lists of member practices as the basis of care delivery. In this way the MCP would become more akin to a PACS. It could own and run small local hospitals and facilities and contract/employ specialists to move as much care as possible out into the community.
- Medical leadership in this model is evident and delegated planning functions are carried out by people with expert knowledge of the health needs of the local population.
- The scale of structural integration could vary. The network might come to dominate community and ambulatory care as a prime contractor or lead service provider with subcontracts ie it could provide or buy services. Contracting methods would have to evolve with this model. Subcontracts, including those with hospitals, may for example be block contracts rather than tariff based as the current tariff does little to promote integrated working
- There may be long term collaboration with local specialist providers, specialists could become partners in these provider organisations or could even become employees.
- Practices' primary care contracts may ultimately be subsumed by these larger population contracts or subject to subcontracting but, importantly, this would be a decision made by the owners of the GP network.
- The purchaser/provider split becomes very blurred as GPs – and maybe other providers - work together to commission, plan and provide for the local population. The blurring of planning and provision in this model would probably have long term implications for CCGs. The purchasing function might in time become more remote as clinical leadership shifts from CCGs to provider organisations.

- There is scope for organisations of this size to aspire to run care outside their geographical area. We need to be aware of this possibility and consider whether it is something that we would consider to be acceptable.

Example - Northern Ireland

Northern Ireland is developing a model of networked federations of GP practices with the explicit intention of integrating care and moving services out of hospitals. Federations have already been established as not-for-profit community interest companies and will ultimately be established across Northern Ireland. Each will comprise around 20 practices delivering services to around 100,000 patients. For now, the GP contract will remain the same. As federations develop into MCPs over the next 3-5 years, it is envisaged that this approach could offer advanced diagnostics, outpatient clinics in for example rheumatology, ENT and neurology and complex care pathways. The Board has requested the rapid development of 3-4 outpatient centres. In the first instance federations will contract with GPs on a peripatetic basis for sessional work eg in outpatient clinics but this may move towards employment of some GPs and other professionals over time.

Vanguard site examples

Lakeside Healthcare, North Northamptonshire

A super partnership of 100,000 with ambitions to grow to 300,000, this GP organisation is working with other providers to extend primary care services and to deliver services such as dermatology, MSK, Ophthalmology, Gastroenterology, Urology, Gynaecology, Rheumatology, Diabetology, Gerontology and Geriatric Medicine using GPwSIs to design and lead the necessary pathways. With nearly 50 partners, the business is managed and run by an executive with clearly defined roles and responsibilities. A key part of the Lakeside offer is how the practice plans to manage the frail and the elderly in its region, based on clearly stratified and understood medical needs and social care assessments. An increasing number of hospital doctors will work alongside the GP partnership, many on an employed basis, either as partners or salaried doctors.

Principia Partners/Rushcliffe (Nottinghamshire)

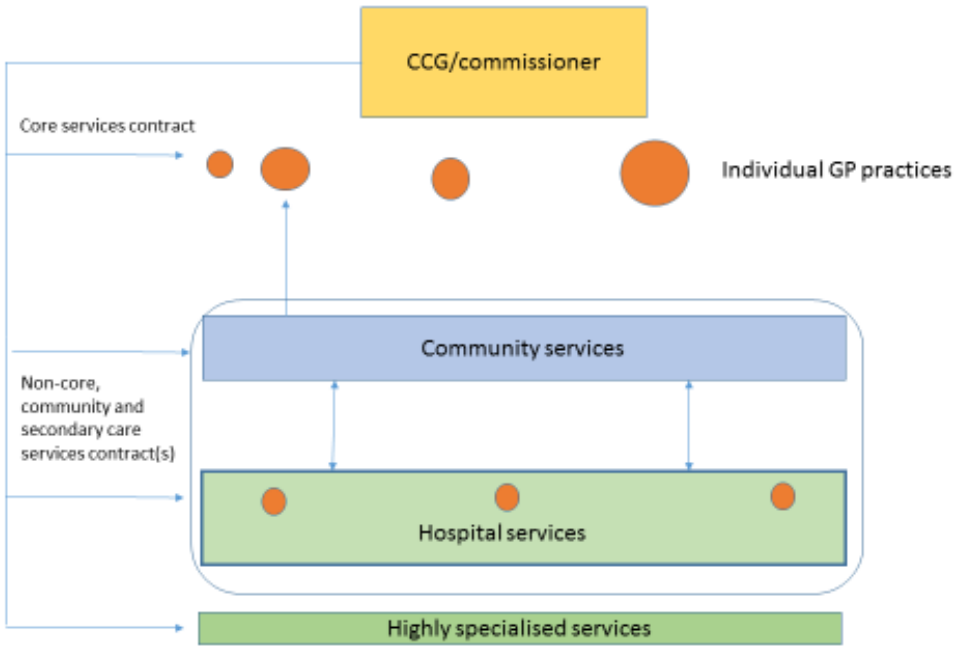
Principia Partners in Health is a GP led organisation (Community Interest Company), covering a population of 126,000. Partners Health will be the foundation of an MCP with ambitions to accept contractual responsibility for the health of Rushcliffe's population using capitated outcomes based contracting for health and social care.

Primary and Acute Care Systems (PACS)

The 5YFV describes Primary and Acute Care Systems (PACS) as a new variant of integrated care allowing single organisations to provide list-based GP, hospital, community and mental health services. The leadership to bring about these 'vertically integrated' PACS could be generated from different places in different local health economies. For example, hospitals could take over or open their own GP surgeries (APMS contracts) or mature MCPs could take over the running of the main district general hospital. The 5YFV states that at their most radical, PACS would take accountability for the whole health needs of a registered list of patients under a delegated budget.

The example model below shows in very simplified diagrammatic form a Foundation Trust based PACS in the early stages of development. This model is one possibility under the 5YFV proposals and is exemplified by some of the vanguard sites. The PACS could emanate from a single Trust or a group of Foundation and Community Trusts. Commissioner involvement is very likely from the beginning in PACS development but involvement of GP providers could be minimal. This is perhaps particularly likely where primary care is struggling and general practice is fragmented.

A Foundation Trust based PACS model



A Foundation Trust based PACS model in the early stages of development - The hospital has started to host, manage or deliver some primary care services and is beginning to integrate with community services

Features of a hospital led PACS model in the early stages of development could be:

- The CCG contracts directly with most general practices but also increasingly with the hospital as a prime contractor for services, including perhaps some primary care services

- The hospital provides some list-based GP services alongside hospital services, mental health and community care services. [Some hospitals already provide/host community services making this part of the model a more straightforward transition, whereas Trusts have very little experience of delivering primary care.]
- The hospital may tender for new primary care contracts, employ some GPs, subcontract to practices or enter into partnership arrangements with existing GP contract holders, leading towards vertical integration. Some practices are particularly vulnerable, including those struggling organisationally or financially. There may therefore be implications for GP contracts, employment and services. For example, more GPs could become Trust employees and an increasing proportion of enhanced services contracts could be held by the PACS leaving independent practices with the provision of core services.
- Primary care may come to feature heavily in this model of service delivery to reduce overall costs but it is unlikely to be driven by GPs or based around today's practices or group arrangements.
- Medical leadership is not necessarily evident in this model as the Foundation-Trust based PACS could be driven heavily by managers. Alternatively, hospital consultants might play a significant role.

Example PACS vanguard site – Mid Nottinghamshire CCGs

A formal alliance of 7 organisations including Foundation Trusts, Trusts, Ambulance Service, the out of hours provider and Circle has ambitions to deliver whole system integration of hospital, community, social and primary care within a single outcomes-based capitated contract. At the moment it is working through a formal alliance with many details about how it will operate still to be firmed up including the nature of involvement with general practice, social care and the third sector.

There could be varying degrees of structural integration under a Trust-based PACS model. Full integration - including progression to a single organisation responsible for all the health needs of a given population - is possible over time and may be the aspiration from the start.

Features of a mature Foundation Trust based PACS organisation could be:

- A Trust or provider alliance is responsible for most/all healthcare provided to a defined population. The provider probably receives capitated funding. This sort of arrangement is commonly referred to as an Accountable Care Organisation.[4]
- There are few competing providers in the local health economy
- The provider dominates community and ambulatory care. It could provide all of this care directly or be a lead contractor subcontracting certain services to other providers.
- Aspects of commissioning and provision may ultimately merge as the provider organisation takes on more responsibility for planning service delivery.

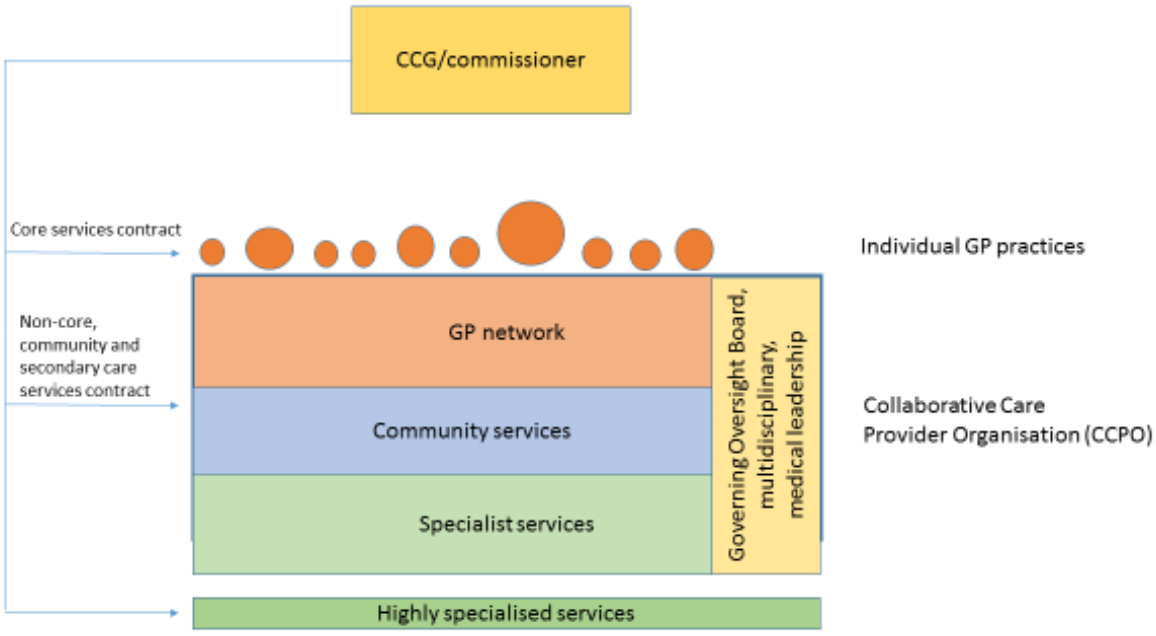
[4] **"**The basic concept of an ACO is that a group of providers agrees to take responsibility for providing all care for a given population for a defined period of time under a contractual arrangement with a commissioner. Providers are held accountable for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target."(Kings Fund, March 2014)

- General practice becomes vulnerable to being incorporated into the PACS either through employment of GPs or subcontracting of primary care contracts from the lead provider.
- It is not yet known if, where GPs are employed by PACS organisations, the use of the sessional GP model contract or equivalent terms and conditions will be standard or whether they would adopt terms and conditions similar to secondary care doctors
- As in the early stages of development, the PACS may decide to invest an increasing proportion of its resources in community and primary care to reduce overall expenditure but there is perhaps also potential within these organisations for resources to be drawn towards acute care.

A multidisciplinary PACS organisation (Collaborative Care Provider Organisation)

The model above describes a PACS dominated by Foundation Trusts. Yet, the 5YFV notes that PACS organisations could also develop out of MCP arrangements. PACS therefore need not preclude GP involvement and, if well designed, might evolve in such a way that the best elements of traditional general practice are preserved.

Well organised GPs, working for example through a GP network, could conceivably become part of a PACS arrangement defined by truly multidisciplinary medical leadership – in the diagram below this 'partnership of equals' is represented by a multidisciplinary governing oversight board which leads the new organisation. We have called this model a Collaborative Care Provider Organisation (CCPO) to distinguish it from PACS models driven by single providers. Patients would also need to be involved in the management of the body.



A model based on this sort of approach would allow room for local interpretation in line with local circumstances. It also allows for a variety of different contracting arrangements and degrees of structural or virtual integration.

Features of a mature multidisciplinary PACS approach

- The CCG/commissioner contracts separately with each individual GP practice for core services based on a capitated budget. This preserves a core offer to patients across England and the best elements of independent general practice.

- Practices working together, for example through a network, have a central part in the formation and management of this CCPO. The CCPO maps onto the GP network but also includes on a 'partnership of equals basis' specialists and community care providers, through a multidisciplinary governing oversight board based on medical leadership. The new integrated care organisation is not therefore a "GP organisation" and risks and responsibilities are shared across the health economy.

- The GP network advises the CCPO on primary care and works within the wider structure/is subcontracted to deliver non-core primary care. The existence of GP networks within the CCPO helps to protect the independent contractor model of general practice.

- The CCG/commissioner contracts with the CCPO (probably a capitated block contract based on the sum of the GP practices' registered patient lists) for non-core primary care work, community and secondary care commissioning.

- The CCPO is responsible for providing (or providing and sub-contracting) all health care for the local population except for the most specialised services. The CCPO could own and run small local hospitals and facilities and contract/employ specialists to move as much care as possible out into the community. The CCPO might start by largely subcontracting with the GP network and specialists but move over time to a more employment based model. Either way, the new organisation blurs the lines between primary and secondary care services and patients experience much more joined up care. Delegated commissioning functions also blurs the lines between commissioners and providers.

- The oversight board, probably working with the CCG/commissioner is able to place heavy emphasis on pathway design. This is facilitated by a much greater alignment of organisational and financial incentives.

PART THREE: DEVELOPING GP NETWORKS WITH A VIEW TO INTEGRATING CARE

The role of GP networks

There are a range of good reasons for GPs to come together to create provider organisations or networks. Promoting high quality general practice and improved patient care should be the foundation. At a time many practices are struggling, networks can support member practices to provide services by sharing good practice, functions, support staff and services. In this way they can preserve and protect all local and viable GP contracts. As independent practices form the foundation of GP networks, GPs retain the ability to respond to their own unique populations.

The prospect of using GP networks to drive the development of MCPs, or in the long term even fully integrated PACS, should be an additional impetus for practices and GPs to join. GP networks are likely to be a good vehicle of transition from current structures towards more integrated care arrangements and, as they are owned and managed by GPs, they are among the most likely ways to preserve the best features of traditional general practice that both patients and GPs value.

Formally constituted GP networks (or in some cases, super-practices) can give GPs a real voice within the health economy, ensuring high levels of grass-roots GP involvement in the development of new care models. As we have seen from the illustrative models above, the alternative could be integrated work heavily directed by the commissioner and introduced contractually, or new care models led by hospitals or community service providers with little GP buy-in.

In some areas PACS development is already underway and true GP engagement may need to begin at a later stage of integration. New GP networks will need to find a place within the ongoing reorganisation of local provider structures and commissioning arrangements. Networks have the potential to act as a buffer, protecting independent practices from domination by other providers; individual practices in some areas will have no real say in the new integrated models unless they can also function as part of a wider body.

The GPC envisages a future where large GP networks are focused on provision of local NHS care and, where greater scale is required, work collaboratively rather than competitively with one another.

Working within networks

If GP networks are to meet the needs of GPs and the NHS, they will need to be developed with care, with consideration given to their purpose, scope, structure, management and employment methods; in short, GPs need to consider the principles which will underpin these organisations.

To evolve into the sort of large scale providers of integrated care set out in the some of the illustrative models above, network membership would need to be geographically based, broadly coterminous with other borders and open to all practices in the area.

GPs need to consider the legal structure and democratic rules of each network. [The legal structure is particularly important and the focus of existing GPC guidance]. GPs must retain a right to

freedom of expression within new provider organisations and medical professionals' duty of candour should be reflected in a culture of honesty.

GP networks should promote good employment practice. At first most professionals, both GPs and others, engaged by a network are likely to work on a peripatetic basis but in time new salaried roles might be created. If terms and conditions of employment for staff are good, the new roles may appeal to some GPs, potentially even creating a new type of career path alongside the traditional partnership model. Of course, this should extend beyond GP engagement to include other staff including specialist colleagues. Good employment practice in networks should include regard to career development, valuing staff, and developing leadership potential.

Networks should seek to involve employed staff, including GPs, in the management and development of the network. Sessional GPs will come to have a critical role in many new provider organisations.

Networks should where possible also involve patient representatives in their planning structures or at Board level.

Working with other professionals

As we have seen, a GP network could become the driving force and central part of an MCP, and eventually even of a PACS, but this development will be determined by local preferences, circumstances and relationships. There could be a variety of different contracting arrangements and degrees of structural or virtual integration. It is possible that in some cases, the GP network will not be the driving force of the MCP or PACS but one constituent part of a wider collaborative organisation which includes on a 'partnership of equals basis' specialists and community care providers.

Future policy development will necessitate formal interaction and collaboration with social care providers. Patients will also need to be involved in the management of the MCP or PACS.

Preparing for change

Exhaustion, change fatigue and disengagement of the GP workforce could be a major barrier to GP led integrated care models. In so far as this model relies on GP leadership, it requires GPs to want increased responsibility for the organisation and delivery of health care and to have the capacity to expand into this role.

To create effective provider organisations and to develop more integrated ways of working, GPs need time to plan, funded premises and infrastructure. Sophisticated provider organisations need a management allowance to operate well. The vision in the 5YFV is not therefore likely to be achieved without additional upfront investment.

In some parts of the country, considerable energy, medical leadership and management expertise is currently being used in CCGs. If health planning, including functions such as pathway redesign currently undertaken by CCGS, starts to take place within MCPs or integrated provider organisations, it may be necessary for clinical leaders in CCGs to migrate to provider organisations. It would also be appropriate for the management resource to move with the transfer of these functions to guard against the risk of responsibility and work moving unresourced from CCGs to providers.

We need to consider how to promote the development of GP networks in line with agreed principles and with a clear vision of a future that works for patients and doctors. Many GP networks are already up and running as the result of energetic professional leadership. It is likely

that commissioning policy will encourage the development of more networks in the near future. Just as in Northern Ireland where strong central professional leadership has promoted network development, Local Medical Committees (LMCs) may now decide to actively promote and support networks (as some have already done very successfully).

The GPC has already produced guidance for GP networks which is available on the BMA website. The BMA is also setting up a network database and aims to develop a community of networks which will in time share good practice and access services.

Appendix 1

Descriptions of MCPs and PACS from the 5YFV

New care model – Multispecialty Community Providers (MCPs)

Smaller independent GP practices will continue in their current form where patients and GPs want that. However, as the Royal College of General Practitioners has pointed out, in many areas primary care is entering the next stage of its evolution. As GP practices are increasingly employing salaried and sessional doctors, and as women now comprise half of GPs, the traditional model has been evolving.

Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients.

Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

To offer this wider scope of services, and enable new ways of delivering care, we will make it possible for extended group practices to form – either as federations, networks or single organisations.

These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients.

• As larger group practices they could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.

• These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.

• They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.

• GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries.

• They could in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers.

• These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

New care model – Primary and Acute Care Systems (PACS)

A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures. We will now permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.

The leadership to bring about these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

• In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to kickstart the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.

• In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.

• At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

Appendix 2

Vanguard sites announced by NHS England in March 2015

As part of the 5YFV, NHS England will pump-prime a cross section of new care models, looking at current exemplars, potential benefits, risks and transition costs. National and regional expertise and support will be harnessed to 'implement care model change rapidly and at scale'.

The Five Year Forward View Into Action: Planning for 2015/16 invited local organisations wishing to become 'vanguard' sites to express their interest to a new care models team. On 10 March NHS England announced that 29 sites had been selected from 269 applications to receive funding from a £200 million transformation fund. The projects (9 PACS, 14 MCPs and 6 care home projects) will be evaluated with a view to replicating successful models elsewhere. Presentations from each of the vanguard sites can be found on NHS England's website:

www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/new-care-models/

Integrated Primary and Acute Care Systems – joining up GP, hospital, community and mental health services

1. Wirral University Teach Hospital NHS Foundation Trust
2. Mansfield and Ashfield and Newark and Sherwood CCGs
3. Yeovil Hospital
4. Northumbria Healthcare NHS Trust
5. Salford Together
6. Lancashire North
7. Hampshire and Farnham CCG
8. Harrogate and Rural District CCG
9. Isle of Wight

Multispeciality Community Providers – moving specialist care out of hospitals into the community

10. Calderdale Health and Social Care Economy
11. Derbyshire Community Health Services NHS Foundation Trust
12. Fylde Coast Local Health Economy
13. Vitality
14. West Wakefield Health and Wellbeing Ltd
15. NHS Sunderland CCG and Sunderland City Council
16. NHS Dudley CCG
17. Whitstable Medical Practice
18. Stockport Together
19. Tower Hamlets Integrated Provider Partnership
20. Southern Hampshire
21. Primary Care Cheshire
22. Lakeside Surgeries

23. Principia Partners in Health

Enhanced health in care homes – offering older people better, joined up health, care and rehabilitation services

24. NHS Wakefield CCG
25. Newcastle Gateshead Alliance
26. East and North Hertfordshire CCG
27. Nottingham City CCG
28. Sutton CCG
29. Airedale NHS Foundation