

## NHS reform

Fisher, Rebecca; Smith, Judith; Sidhu, Manni; Parkinson, Sarah; Alderwick, Hugh

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# NHS reform

## Five key questions about the future of primary care networks in England

Rebecca Fisher, Judith Smith, Manbinder Sidhu,  
Sarah Parkinson, Hugh Alderwick

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## Key points

- NHS England and Improvement have published plans for changes to NHS structures and legislation. The changes aim to support NHS organisations to collaborate to improve care and manage resources, and may mean the abolition of clinical commissioning groups (CCGs) and new area-based agencies being established.
- This long read explores five key questions that the proposals raise for the future of primary care networks (PCNs) in England. We discuss the conditions required for PCNs to find their place within newly established integrated care systems, while continuing to develop and strengthen local primary care.
- The legislative proposals rely on PCNs as a building block of the new NHS architecture. PCNs have the potential to improve quality of care – and early evaluation shows that PCNs have made good progress in getting services under way in a challenging context. But there is a risk that too much is being expected of PCNs too soon. The proposed changes could cause disruption for PCNs and risk diverting them from their core goals of improving integrated care and the sustainability of primary care. At worst, system reform may destabilise these fledgling networks.
- Adequate PCN representation on new integrated care system boards will be essential if the proposed changes are to achieve their goal of enabling better integration between primary care, acute hospitals, mental health, community and social care services. Making sure that the voice of PCNs and primary care within integrated care systems is fair and representative will be challenging.
- The changes proposed for CCGs create uncertainty for PCNs. CCGs have played a central role in PCN set up and development, and are involved in the functioning and monitoring of PCNs. Clinical directors of PCNs will need to invest time in building relationships with the commissioning and support systems that emerge after CCGs.
- The new proposals envisage an expanded role for PCNs at ‘place’ level – districts covering entire local authority areas. There is a risk that PCNs may be drawn away from their focus on delivering care at a smaller neighbourhood level, and working to shore up general practice for the longer term. Primary care buy-in to integrated care systems will be essential if the proposed changes are to achieve their goals.
- The NHS is good at developing new initiatives, and less good at nurturing them over the longer term. New primary care organisations should be enabled to grow organically, focus on local priorities, mature, and develop a true sense of local ownership.

# Introduction

COVID-19 has had a major impact on primary care in England. General practices have had to reorganise services, shift to remote consultations where possible, and learn to work alongside the virus to keep services running. The effects of COVID-19 and social restrictions to control the pandemic are likely to exacerbate chronic conditions and **create additional health needs** to be managed over the long term. Primary care also faces the significant task of **vaccinating the population against COVID-19**. The challenges ahead are enormous.

To further compound the situation, primary care in England may soon also have to contend with the effects of an NHS reorganisation. In November 2020, national NHS leaders in **England published proposals for new NHS structures and legislation**. The main aim of the changes – which could be implemented by 2022 – is to support NHS organisations to collaborate to improve care and manage resources. The proposals include removing requirements to competitively tender some NHS services, creating new NHS provider collaborations (networks of hospitals, mental health, primary care and community health care organisations), and establishing integrated care systems – area-based partnerships of NHS organisations and local government – as new statutory agencies (see Box 1).

The emphasis on collaboration to improve care makes sense – and goes with the grain of recent policy initiatives in the NHS to improve integration of service planning and delivery. The Health and Social Care Act 2012 created a set of complex and fragmented organisational structures that can **make collaboration difficult**. But there are risks attached to structural change in the NHS. Major reorganisation **creates disruption and uncertainty**, and could divert leaders and managers from the core business of providing safe, high-quality services for patients.

NHS England's proposals rely on primary care networks (PCNs) as a key building block of the new NHS architecture. **PCNs are relatively new** – established in July 2019 as groups of general practices in England, covering populations of around 30,000–50,000 people. PCNs are designed to support collaboration in primary care and help develop more integrated health and care services in the community. National leaders hope that PCNs will improve the range and effectiveness of primary care services while maintaining the independence of individual practices. PCNs are also intended to boost the status of general practice in the wider NHS, creating opportunities for primary care to work more closely with other parts of the NHS, such as acute hospitals. **Almost all GP practices in England are part of a PCN**. But these organisations are nascent and may prove to be particularly vulnerable to any NHS upheaval.

PCNs have the potential to improve local services and contribute to better population health. The proposals from national NHS bodies currently lack detail, so it is too early to make a full assessment of their likely impact on PCNs. In this long read, we draw on findings from the recent University of Birmingham, RAND Europe and Cambridge (BRACE) Rapid Evaluation Centre's **study** of the first year of PCNs (funded by the National Institute for Health Research), to ask whether the networks are ready to undertake the role envisaged for them. We identify five key questions raised by the proposals about the future of PCNs in England and explore the challenges to overcome if the strategic direction described by national NHS bodies is to be effectively pursued. We end with considerations for policymakers to focus efforts on in the coming months, as legislative proposals are developed further.

## Box 1: Brief summary of proposals from NHS England and NHS Improvement

*Integrated care systems* – England will be divided into 42 integrated care systems, established as collaborations between NHS providers, commissioners and local authorities. Integrated care systems will cover populations of 1–3 million, and will each control a ‘single pot’ of NHS resources. Each integrated care system will have a named leader and chair, and will make collective decisions about how to distribute resources. This might include delegating funding decisions to ‘places’ within their boundaries.

*Places* – NHS organisations will work with local authorities and third sector providers to organise and deliver health and social care in ‘places’. These are likely to be defined by existing local authority boundaries. PCNs – which will continue to work at smaller ‘neighbourhood’ levels (typically covering 30,000– 50,000 people) – will be a key mechanism for joining up services within places as well as at neighbourhood level.

*Two options for integrated care systems* – NHS England sets out two options for the formation of integrated care systems. The first would see integrated care systems be established as joint committees of existing statutory organisations, overseen by an accountable officer. The second option – NHS England’s preferred route – is that integrated care systems would be created as new NHS bodies. CCGs would be abolished, and their functions taken up by the integrated care systems, which would have a chief executive and a board made up of representatives from NHS providers.

*Changes to national NHS bodies* – Legislation will be needed to formally merge NHS England and NHS Improvement to help provide ‘a single clear voice’. These national bodies will shift focus to regulating and overseeing these new systems of care.

Source: **Integrating care: Next steps to building strong and effective integrated care systems across England.**

# 1. How will changes to clinical commissioning groups affect PCNs?

The options set out by NHS England in its consultation paper spell significant change for clinical commissioning groups (CCGs). Even if there is no legislative change, NHS England wants all CCGs to merge to match an integrated care system footprint – a significant shift since there are currently 135 CCGs and will likely be **42 integrated care systems**. But this is NHS England's second choice. Its preferred option ushers in more sweeping reform – the end of CCGs, with commissioning functions folded into the new integrated care systems.

This causes uncertainty for PCNs. For better or worse (and we know from our research that there are examples across the spectrum), CCGs have played a central role in PCN set up and development. Under delegated arrangements with NHS England, CCGs carry out contract management of primary medical services, including distributing and monitoring most PCN funding. PCNs report to commissioners on network services – including progress on recruitment, achievement against service specifications, and on advances necessary to unlock additional funding from the investment and impact fund (**incentive payments for networks based on delivery of defined services**). **CCGs are involved in the development, functioning and monitoring of PCNs**. Uncertainty about the future of CCGs will inevitably have knock-on effects for PCNs, with potentially destabilising consequences.

There will be an impact on relationships too. PCN clinical directors have invested significant time and energy in developing working relationships with CCG officials, whose future roles are now in doubt or may change. Clinical directors risk losing these links, and will likely need to invest extra time in developing equivalent relationships and ways of working in whatever primary care commissioning and support system emerges from the remains of CCGs.

## 2. What are the implications for PCN leadership and the voice of general practice?

NHS England is clear that integrated care systems should ‘embed system-wide clinical and professional leadership’ through their local integrated care system partnership board, including ‘primary care network representation’. This makes sense: PCNs are important primary care ‘provider collaboratives’ (to use the terminology of the new proposals) in the current NHS landscape, funding and delivering an expanding range of local services. PCN representation on new integrated care system boards – along with primary care buy-in to the process of their development – will be essential if the proposed changes are to achieve their goal of enabling better integration between primary care, acute hospitals, and other services.

But this will not be easy. PCN clinical directors are not perceived as having equal standing with the clinical or managerial leaders of larger NHS providers, such as hospitals and mental health or community trusts – nor do they have as much time allocated to the managerial part of their role. Clinical directors are usually practising clinicians, working in an overstretched primary care system, and are typically funded as 0.25 whole-time equivalent for their PCN leadership role. In comparison with prior forms of primary care involvement in local planning and commissioning, there is no designated national funding for management support for PCNs (although some CCGs have sought to remedy this through PCN development funding), and the job description for clinical directors is wide-ranging and expanding. Many PCN clinical directors are also in their first leadership role and hence still getting to grips with management and leadership responsibilities. As emergent organisations in need of nurturing, PCNs will need additional management support (including funded managerial roles) so that their clinical leaders can carry out these various leadership roles effectively.

The new proposals from NHS England and Improvement do not specify what PCN representation on an integrated care system board will look like in practice, but it is likely that PCN clinical directors will not each have a say at this level, instead nominating one of their number to represent them. This is logical, as integrated care systems will cover populations of around 1–3 million people, and may include as many as 60 PCNs. The recently published BRACE Centre research highlights that PCNs are at varying stages of maturity, based on a number of factors. These include previous collaborative relationships in local general practice, the degree to which practices in a PCN share similar patient populations and working cultures, and variation in the level of management, leadership and support available from their CCG. There may be a challenge in ensuring genuine primary care representation, avoiding the likely tendency for system-leadership seats to go to clinical directors of the more influential and evolved PCNs in an integrated care system.

To ensure representation from all PCNs within an integrated care system, networks will likely need to work out an approach to fairly and collaboratively represent themselves. This might include establishing a group for PCN clinical directors within an integrated care system, from which one or more representatives are nominated to the integrated care system board, contribute views from PCNs to influence integrated care system policy, and report back to local PCNs and constituent practices. The price of increased collaboration and fairer representation across PCNs may be increasing bureaucracy, and taking time away from the core functions of PCNs at neighbourhood and community level.



### 3. Are PCNs mature enough to withstand the changes ahead?

Evaluation of the implementation and early development of PCNs reveals that they have established themselves swiftly and made good progress in [getting new services under way in a challenging context](#). But PCNs are at risk of having too much expected of them too soon. Their fragile management and organisational arrangements may come under undue pressure if required to fulfil too many nationally specified service requirements, particularly when still establishing local arrangements to strengthen and extend primary care.

The impact of COVID-19 on PCN development has been significant. [COVID-19 drew some PCNs together](#) – for example in the creation of ‘hot hubs’ to offer rapid assessment of patients with suspected COVID-19 symptoms. Other areas fell back on previous forms of local collaboration instead – for example where an existing GP federation or out-of-hours cooperative was better able to provide a now-necessary service. The pandemic derailed the timeline for the introduction of some aspects of the PCN service specifications (some such as anticipatory care were delayed, while others such as enhanced care home support were brought forward). Furthermore, although money remains available to PCNs, the pandemic has made recruiting additional roles more challenging. In winter 2020–21, as consultation on the new legislative proposals continues, PCNs are playing a central role in delivery of the COVID-19 vaccine programme, with no clarity as to how long this may last, nor what impact it will have on core PCN activity.

Establishing PCNs as well-functioning networks – engaged with and responsive to the needs of their local communities, and working with other NHS, social care and voluntary sector providers – was always a challenge when working to tight timelines. The first year of the 5-year PCN contract was intended for network setup, but was interrupted by COVID-19. The pandemic has monopolised the second year of PCN working and seems likely to continue to impact the third. The legislative changes proposed by NHS England are intended to come into effect in 2022, but will likely cause disruption before and after implementation, as NHS managers and leaders become busy doing what they have done so many times before: planning and enacting a reorganisation of local governance, management and other structures. If the new proposals are implemented, the entire lifespan of PCNs, as set-out in the *NHS long term plan*, will be played out against a backdrop of disruption.

The BRACE evaluation shows that while PCNs have mobilised quickly, they vary significantly in their organisational capacity and maturity. This has been described in [previous studies of primary care organisational development](#). At best, disruption from the likely organisational changes in the NHS will be an opportunity cost for PCNs – time invested in dealing with the effects of system change that might otherwise have been spent elsewhere. At worst, system reform may destabilise fledgling PCNs, stretching the limits of their resilience.

## 4. Do these proposals threaten PCNs' original purpose?

PCNs are expected to deliver a set of nationally-defined 'service specifications' covering areas such as improving early cancer diagnosis, supporting better health in care homes, and reducing health inequalities. In addition to fulfilling their contractual requirements, PCNs are expected to contribute towards a loftier goal: a more integrated local health and care system, where the NHS works with local government and other community partners to improve population health and reduce inequalities. This vision is what attracted many early supporters of PCNs to become involved.

But with that vision comes a potential tension: how can PCNs be 'of the neighbourhood' and 'of the system', and play both these roles effectively? The new proposals suggest that in addition to delivering services at the neighbourhood level (30,000– 50,000 people), PCNs will be expected to play a central role in the new 'place' level in the NHS – a more formally established tier of health and social care partnerships based around existing local authority boundaries. The proposals do not contain detail on the role PCNs are to play at place level, but there is a clear expectation of expanded responsibilities.

NHS England's proposals also create ambiguity about future relationships between PCNs and other health and social care providers. As collaborations between general practices, PCNs are already provider collaboratives. But the proposals also call for new 'vertical' collaboratives – for example between primary, community, mental health and acute hospital services in a given area. How PCNs will function within these additional collaborative arrangements – and whether doing so will create a further governance and management ask – is unclear. Experience suggests that local partnerships between health and social services agencies are complex to manage and deliver – with expectations often exceeding what is achievable (Glasby et al 2011, Hayes et al 2012).

In some respects, PCNs are caught in a bind. Fail to represent themselves effectively at system level, and PCNs may risk losing out when key decisions and resource allocations are made. But the need to have system-level representation will present an opportunity cost for PCNs. PCNs are small general practice collaboratives with big and expanding to-do lists, including the pressing need to recruit new roles to fulfil their contractual requirements, and needing to secure and sustain the engagement of local primary care teams. As such PCNs may find themselves drawn away from their original purpose – delivering local care at neighbourhood level, and shoring up general practice in the process. This is a dilemma witnessed on countless occasions with prior primary care-based collaborations, whether focused on commissioning (eg GP fundholding, practice-based commissioning, GP commissioning) or provision (eg personal medical services, primary care trusts).

## 5. What conditions are needed for PCNs to work within the new proposals?

The long history of attempts to reform NHS architecture features familiar refrains. Time and resource are expended on the process of organisational change, managers and clinical leaders are often diverted from the vital (and more difficult) work of changing and improving local services, and promised financial and service benefits are rarely delivered at the anticipated scale (for examples see Mays et al 2011, Edwards 2010, Exworthy et al 2016).

The NHS is good at coming up with new initiatives, setting up structures and governance arrangements, and responding quickly to central policy direction. It is much less good at letting new primary care organisations focus on local priorities and giving them the time (years not months) to get going and prove themselves, developing a true sense of local ownership of primary care development. And the NHS has struggled to identify and apply meaningful measures of success for newly forming primary care organisations. Much learning could be gained from New Zealand, where the independent GP-owned and led practitioner associations of the 1980s and 1990s continue to thrive, having morphed into primary care provider and support organisations with a strong focus on population health. These organisations have been able to pursue a mix of local and national objectives, received additional funding for expanding responsibilities, and continued as locally-led, GP-governed entities.

If the new integrated care proposals draw PCNs from communities towards the wider health and care system, and away from their core focus of developing and extending local primary care, there is a risk that primary care teams may come to feel that their PCN is no longer theirs, but is 'of the state'. This risk will be magnified if the need to straddle both neighbourhood and place results in PCNs merging to become larger primary care provider organisations. The experience of primary care groups and trusts from 1999 to 2002 is salutary here, as is that of practice-based commissioning.

## Considerations for NHS leaders

Change in the NHS landscape seems inevitable – and the emphasis on collaboration at the heart of the new proposals fits with the existing direction of NHS policy set out in the *NHS long term plan*. But the proposals also carry risks for PCNs. PCNs will need to find their place within newly established integrated care systems, while also continuing to develop and strengthen local primary care – all in the context of additional pressures created by COVID-19. To help address the risks described here, NHS leaders should consider the following as they further develop their plans for new NHS legislation over the coming months:

- PCNs will need to work together to identify the needs of primary care within integrated care systems and how they vary depending on local context. System-wide priorities must be balanced with the need to support locally-led changes by PCNs and their partners.
- Governance and decision making within integrated care systems should be inclusive and flexible enough to allow fair representation of all PCNs. This means developing mechanisms to avoid the risk of more mature PCNs dominating decision making, or variations in local context for PCNs not being recognised in system-level planning.
- Clarity is needed on how much control integrated care systems will have over PCN budgets and decisions (or how the level of control will be determined by local systems).
- Clarity is also needed on the involvement and role of PCNs in the new 'place' tier of the NHS. This includes defining which organisations are accountable for which population health needs, as well as the support given for any expansion of PCN responsibilities.
- Time and resources will be needed to support relationship building between PCNs and integrated care systems, particularly where there are currently strong working relationships between PCNs and CCGs (which may be lost in the new arrangements).
- The intended benefits of the new arrangements should be clearly articulated to PCN leaders and local primary care teams. A nuanced approach to measuring and monitoring the progress of PCNs within integrated care systems should be developed, allowing flexibility for PCNs to address local needs alongside broader system goals.

# Supporting information

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