Myth-busting PCNs

PCNs will be harmful to patients, the NHS and the profession; PCNs will fundamentally undermine General Practice; PCNs will micro-manage practices

PCNs are GP practices (groups of practices that join together to make the decisions), as well as other organisations who provide health and social care to patients. Therefore, there is no PCN to manage practices, it is a group of practices that collectively make decisions for the practices within that PCN.

PCNs will integrate care across larger populations, providing increased opportunities for access for patients and quality improvement (among others); as well as increased opportunities for GPs and other healthcare professionals.

The BMA has policy in support of integration of care, especially where that integration is led from the ground up. The GPC negotiated the contract such that PCNs are created by practices and on an opt-in basis (ie a Directed Enhanced Service).

The development of PCNs is a major shift of work out of hospitals with plans for more cuts, closures and loss of outpatient appointments

The five-year framework for the GP contract explains where new services will be developed by general practice and PCNs. This outlines seven services, building on examples already in operation across England, which will be developed for PCN level integration.

The details of each of these services is yet to be agreed and will be done as part of the annual national GP contract negotiations (led by the GPC England contract negotiating team) and approved by the GP Committee (England). Where there is overlap or impact on secondary care (or any other care sector) the GP committee liaises with the relevant secondary care committees.

This is not about shifting work from one care sector to another but is about ensuring care in different sectors is appropriate, complementary and non-duplicating, ensuring care is joined up and supports integrated delivery of services so for a patient the journey is seamless from one part of the system to the next. There is no intention for the introduction of PCNs to lead to a cut in services elsewhere or to hospital closures, indeed new funding has been provided so this does not happen. One of the intentions of PCNs is to reduce the number of *unnecessary* admissions to hospital by improving care outside of hospitals, often working closely with secondary care clinicians.

Funding for additional work is for a down-skilled medical workforce; care navigation will increase risk to patients of delayed diagnosis/wrong treatment and will provide an inferior service

The former secretary of state pledged to increase the GP workforce by 5,000 but that was unachievable. We have been clear that there need to be more GPs working in general practice and we are awaiting the NHS workforce plan for details of how they hope to achieve this.

However, there is much we can do to improve services for patients and workload for practices; one way we have agreed to do this is to introduce highly skilled health and social care staff via PCNs. Many practices, and their patients, are already benefiting from employing pharmacist and having physiotherapists as part of their team alongside practice nurses and other healthcare professionals. We do not believe that the new workforce will provide an inferior service, in fact quite the opposite as it means that patients will have direct access to appropriate professionals dependent on their specific needs (potentially speeding up diagnosis and appropriate treatment). It also means that practices and GPs should have a reduced workload, which should further incentivise a career in general practice.

GPs/practices will have to sign a parallel contract to join a PCN, having legal force; those signing up to the PCN will become contractually bound

Practices will need to sign up to the DES, just as they do for other DES'. These are voluntary and so practices can decide whether or not to sign up. If practices decide to sign up, they will need to make some agreements between them for how the PCN will operate; this is called the Network Agreement. This is a legal document and practices will be legally bound into it in order to protect member practices and enable good working arrangements between them, in a similar way to a practice partnership agreement. It includes a process for leaving the PCN and the agreement should that be necessary.

The agreement is in force as long as the practices continue to opt into the PCN DES, which is an annual process.

PCNs will take over practices and their daily work

The five-year agreement outlines new services that will be delivered at PCN level and some high-level agreements on some areas where care might be better organised at a locality level, while still being delivered by practices.

As PCNs are created by practices, and decisions would require the practice members agreement, PCNs will only take over practice work if practices agree to that.

Patient lists and practice budgets will be handed over to PCNs, with them becoming locked-in over time

Each practice will continue to hold their own practice list – this will not be handed over to PCNs. Indeed, PCNs are simply a collection of practices and other organisations (agreed by the practices) and so there is no one to hand over the list to. Practices will share patient data with other members of their PCN so that care can be delivered in a more coordinated and seamless manner.

PCNs, being a collection of practices who are empowered to make collective decisions, will only have control of budgets in as far as the practices decide. Therefore, practices will only hand over any funding, if the PCN practice members collectively decide that is the best way for them to operate.

Funding will be provided from NHS England and the Commissioner directly to the PCN for practices to decide how to operate. This is new funding and not within individual practice budgets.

As the BMA continues to negotiate the GP contract and by extension the PCN DES, any future decisions about funding will be subject to national negotiations, but there is no intention for PCNs to take over from practices.

GPs will lose job satisfaction

One of the benefits of PCNs is that they may reduce GP and practice workload by sharing work across an increased and wider workforce. Rising workload is the number one issue for GPs affecting their job satisfaction, therefore PCNs are likely to increase job satisfaction if they do result in a reduction to individual practitioner workload.

PCNs' objective is to save money by denial of care in order to meet targets; PCNs will provide financial incentives to not refer to hospitals

PCNs are being created, as part of the five-year GP contract agreement, with new NHS funding. This is not funding that has been taken from anywhere else and is in additional to new funding going directly to practices.

There is no suggestion in any of the documentation that PCNs will deny care to patients, indeed practices cannot deny care that they are obliged to provide via their core contracts. There is no suggestion in any of the documentation that PCNs have targets or have funding attached to targets.

The contract documentation does refer to an impact and investment fund which is new funding that will support PCNs in making a positive impact elsewhere in the system. The details of the fund will be negotiated later this year.

PCNs create the foundation of Integrated Care Providers, which will lead to the corporate take-over of the NHS

PCNs are required to engage with their Integrated Care Systems as practices were required to engage with their CCG. ICSs are regional groups of health and care organisations that work together collaboratively across larger geographies, and in many cases mirror the areas previously covered by Strategic Health Authorities. The aim is to enable greater collaboration across a region and integrate care appropriately across the health and care system. There may be many PCNs within an ICS, just as there might be many other NHS and non-NHS organisations within an NHS.

The government has recently approved the creation of new organisations known as Integrated Care Providers. These are very different to PCNs and practices would have to give up their core contract to be involved in this organisation and we therefore do not support this model of operation. The BMA has long raised concerns about the potential for private organisations to be the ICP.

Shoring up further NHS organisations within an ICS cannot lead to an easier take-over by a private organisation acting as the ICP; practices still maintain their individual contracts and cannot be forced to give these up in order to become part of an ICP.

This change requires a vote of the profession

The changes agreed to introduce the PCNs are building on the GP contract, via a DES. The GPC negotiates the GP contract on an annual basis, including DES', therefore in this regard there is no difference to any normal contract negotiation.

It's the role of GPC England, as the body elected by GPs to represent their views to consider contractual changes and take a view on whether to accept them or not. This is also done in the knowledge of LMC conference resolutions. Therefore, GPC had a long discussion on the contract and voted almost unanimously in support of the contract changes.

We recognise that the changes to the GP contract this year, particularly the formalisation of PCNs, is a big change. Regular meetings throughout the GP contract negotiations have been held between the chairs of committees of different doctors to keep them informed of progress.