Primary Care Network
NHS Confederation

The future of primary care

February 2025

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About us

NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities. For more information visit www.nhsconfed.org

The Primary Care Network is part of the NHS Confederation. It supports, connects and empowers primary care members to maximise the impact they have on patient care and drive change. For more information visit www.nhsconfed.org/primary-care

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Key points

- This report is the result of a series of engagement sessions with members and integrated care board (ICB) directors of primary care to consider what the future primary care system could look like and the conditions and enablers necessary to deliver the vision.

- It is intended for primary care and integrated care system (ICS) leaders and policymakers within the Department for Health and Social Care (DHSC) and NHS England, and sets out short- and long-term recommendations including:

  — **DHSC should work with ICSs to agree on a metric for the care closer to home shift** to help national and system leaders assess and report on progress.

  — **Commission a review of the Carr-Hill formula to better address deprivation and rurality issues**, informed by the work in Leicester, Leicestershire, and Rutland (LLR) and Frimley.

  — **Support the development and commissioning of primary care at scale providers** (primary care provider collaboratives) **to provide additional services** such as urgent treatment services, diagnostics and day surgery, with greater involvement in ICS elective reform plans.

  — **Reform general medical services regulations** to allow limited liability partnerships (LLPs) to hold contracts and update NHS pension regulations to allow LLP partners to contribute to the NHS Pension Scheme. This step will enable general practitioners to limit their individual liability or risk associated with the business. This structure is commonly used in other partnership models, for example the legal profession.

- **Prioritise reforms in the dental contract** to overhaul the use of units of dental activity to incentivise improvements to patient outcomes over volume of activity.

- **Ensure a new community pharmacy contract sufficiently renumerates activity and medicine costs**, and **recognises the skills and capabilities** that exist, enabling pharmacists to work at the top of their licence. This will unlock innovation and much-needed system capacity.

- **Create a shared-ownership model for primary and community data** that removes the sole data controller responsibility from general practice. This should be grounded in improving data sharing and reducing the administrative burden and risk placed on individual GP practices.

- **Review the effectiveness of the NHS 111 algorithms and develop a system with primary care at scale** with greater capacity to manage risk and improve continuity and patient experience.

- **Remove all role caps associated with the Additional Roles Reimbursement Scheme** (ARRS), allowing primary care networks to recruit the skill mix appropriate for their population.

- **Reform Section 75 of the NHS Act** to enable greater integration and pooled budgets across providers. This would involve allowing a greater breadth of organisations that can pool budgets and greater range of services provided.

Background

The case for change

Lord Darzi's investigation into the NHS in England stated that the NHS is broken and in need of support.[1] Since the pandemic, primary care has been in an increasingly fragile state, contending with workforce shortages, crumbling estates and outdated IT and phone systems. These issues have contributed to an access crisis, which threatens the relationship with patients and the wellbeing of staff. The government, DHSC and NHS England seek to address these challenges through the ten-year health plan and the three key shifts from hospital to community, analogue to digital, and sickness to prevention.

The current acute-focused model has become increasingly unsustainable, and failure to address this risks running counter to the government's ambitions for both the economy and the NHS. Most NHS patient contact occurs in primary and community settings. Despite longstanding commitments towards a 'left shift' (services moving from secondary care into the community), the NHS has experienced significant 'right drift', with resources more concentrated in hospitals.[2] DHSC spending on primary care has decreased from 8.9 per cent in 2015/16 to 8.1 per cent in 2021/22. In the same year, acute hospitals received the largest share of DHSC funding (£83.1 billion), while primary care received £14.9 billion.

Research shows that for every pound invested in primary and community care yields approximately £14 in economic value, proving an economic case for investment.[3] The growing population, rise in chronic disease prevalence, widening health inequalities, economic inactivity and mounting workforce pressures require a shift toward a proactive and person-centred health and care model driven through greater primary and community-care provision and neighbourhood leadership.

The opportunity for change

The ten-year health plan has the potential to reform the NHS into a service for the future; a service that provides high-quality, integrated and innovative care, is a great place to work and a vibrant economic and community hub. But it follows a series of plans with similar ambitions but with limited impact or longevity.

GPs and pharmacists typically spend 30-40 years working in primary care, while practice managers average 20-30 years. In the last 20 years alone, these professionals have seen six Health and Care Acts to reform the NHS and a further eight NHS plans to reform or recover the health service and its workforce. The number grows when plans focused on recovery and sector or pathway-specific reports are considered. This is not to suggest that all have failed, but an acknowledgement of the history that has contributed to a sense of cynicism among our members. Despite this cynicism, a deep commitment to improvement and community health and wellbeing remains a priority for primary care.

Successful change initiatives require buy-in from the people who will deliver the change. They demand active participation and support from all stakeholders across all phases, from initial planning to final implementation. While a clear vision is crucial, it is equally important to foster a change in behaviours and practices at all levels, encompassing top-down, bottom-up, and lateral approaches to translate visionary plans into meaningful sustainable improvements.

At the heart of this report is a commitment from our members to help drive that change. It is based on engagement with primary care providers across England, integrated care board directors of primary care and Healthwatch, and puts forward a vision of a new proactive, community-led and innovative model of care, with citizens at its heart. It details how this can be achieved and draws inspiration from international examples that have strategically combined investment with reform.

While we recognise primary care as the driving force that can make this vision a reality, the centre needs to create the environment for this to be

possible. The recommendations we put forward are steps towards creating a sustainable, equitable and effective healthcare system. By addressing these areas, the NHS can secure its future through collective effort and genuine commitment to long-term change.

Methodology

Throughout 2024 we worked with our membership which contains general practice at-scale, optometry, dental and community pharmacy, and with support from Healthwatch, to assess and challenge the current model of primary care. Building on our 2023 vision for primary care,[4] we conducted a series of engagement sessions with members and integrated care board (ICB) directors of primary care to consider what the future primary care system could look like and the conditions and enablers that would be necessary to deliver the vision. We identified key themes, including access, workforce, digital, data and infrastructure, and considered how each could be supported through the government's three key shifts.

The output of these sessions has been used to articulate our vision and recommendations for designing and implementing a new way of working in primary care.

Primary care in a neighbourhood health service

The NHS is one of the most centralised healthcare systems in the world. The high level of central control and oversight results in bureaucratic hurdles for providers and separates commissioners from local needs. This environment has hampered many of the key strengths of primary care, such as agility, financial efficiency and its strong relationship with patients. These factors foster the skills to support the whole person rather than just their condition.

By decentralising decision-making, investing in shared infrastructure, expanding multidisciplinary teams and working as a better partner across neighbourhoods and places, the NHS can unlock the potential of primary care in improving health outcomes and reducing inequalities. This would give frontline neighbourhood teams the autonomy, resources and flexibility to innovate to ensure that care is not only closer to home but more effective and sustainable for the future.

Overcentralisation has also led to cultural clashes between primary care and the wider system by focusing decision-making and budgets in secondary care, where oversight is more pronounced. This has resulted in years of underinvestment in primary care and underrepresentation at system level.

Previous attempts to decentralise, such as the creation of ICSs, have been progressive steps in the right direction, but a further shift is required to deliver necessary improvements for patients and to ensure stability in primary care. The move towards a neighbourhood health service seeks to combine the advantages of the expertise, agility and connection of voluntary, community and social enterprise sector (VCSE), community and local general practice to the benefits of larger at-scale primary care infrastructure, balancing personalised care with operational efficiency.

While the recent neighbourhood health guidance focuses on the potential for more cross-sector working and a strong relationship with citizens,[5] it does not offer a comprehensive understanding of what a neighbourhood health service would look or feel like for citizens or staff.

What is a neighbourhood health service?

A neighbourhood model of care puts people, communities and relationships at its heart, moving from an industrial to a social model for the public sector. It responds to a community's needs in a proactive way informed by high-quality data with a diversity of frontline expertise embedded in the communities it serves. It is a model which requires the NHS to work with partners to foster collaboration 'close to home' among different health and social care professionals and with communities and the voluntary sector. It promotes knowledge sharing, joint problem-solving and innovation resulting in service design and delivery that meets the needs of citizens.

It:

1. provides wraparound care for those who need it most
2. promotes health and wellbeing through a better relationship with citizens
3. increases community resilience.

Providing wraparound care

High-intensity users comprise a small proportion of the population but use up to ten or 20 times as many resources as other citizens. Yet, despite all that activity, the system often fails to help them improve their lives. We therefore need a new model which complements the NHS's bio-medical model with a psycho-social approach. The emphasis is on seeing the patient in the round, helping them solve whatever problems are most standing in their way and empowering them to take greater control of their lives and their health. While these non-health interventions can be seen as a marginal to core NHS business, this kind of approach is not only more effective

and more compassionate but saves money by reducing demand and unnecessary activity.

Promoting health and wellbeing through a better relationship with citizens

The second necessity for neighbourhood working to fulfil its potential is a stronger and deeper relationship with communities. We know that the public sector can benefit from working respectfully with communities, seeing people, their relationships and connections as assets to promote health and wellbeing, with greater citizen activation not just managing their own health (prevention) but a greater focus on health promotion. We shouldn't miss the potential of neighbourhood working to drive a step change in our relationship with the people we serve. That requires a shift in the culture and the infrastructure in equal parts, so the system is better set up to give power to frontline staff and communities in designing local services plans that work for them and their community.

Core to this is investment in roles within communities, for communities, that bridge the connection between the public sector and communities and drive relational care in the communities.

Increasing community resilience

It is important that this focus on neighbourhoods is built around trusted bodies and familiar expertise that are rooted in communities. When we consider this for health this is typically general practice or community pharmacy, the providers on the high street of many communities or social care workers and district nurses who provide care in and around the home. But many in communities put their trust in the voluntary and community sectors. We need to strengthen and better connect what is trusted, familiar and working, while also responding to deficits in community social capital which results in increased pressures on statutory services as communities. This is particularly important if we are going to tackle deep-rooted health

inequalities. Targeted place-based funding and outcome measures should consider Marmot indicators measuring social determinants of health, the Health Inequalities Dashboard and Fingertips.

The three core components of a successful neighbourhood health model are:

1. Integrated systems

Effective neighbourhood models require the right infrastructure driven by the ICS and place integrators (place-based partnership, provider collaboratives or local appropriate infrastructures), including aligned commissioning and contracting, shared data and digital capabilities, population health informed risk stratification, and leadership strategies that connect neighbourhoods to system priorities.

2. Community led

Community insight and experience shape the way care is delivered and designed, strengthening citizens' control of their health and care, building on local assets and creating community resilience, bridging gaps between statutory and non-statutory organisations and communities.

People tend to define their own neighbourhood in ways that reflect the local geography and history where they live. For their purposes, public services tend to define neighbourhood on larger scales, often based on its statutory or service boundaries. For example, a primary care network reflecting its constituent GP practices, or a district council area within a larger local authority footprint. But this only seldom represents a neighbourhood that local communities and residents might identify with.

Building a singular consensus around geographic borders in this context is likely to be an impossible task. Therefore, instead of spending too much time on definitions, statutory services need to focus on 'thinking neighbourhood' in all they do, including in taking time to understand the local population, to engage them in developing insight and data, and in leading on local change.

3. Team-based care

We need to properly harness the expertise and intrinsic motivation to do the right thing on the frontline – particularly those in the NHS, local authorities and VCSE who want to do this work and are driven by this type of work. These means levels of trust and accountability that allow these roles to provide holistic care as part of cross-organisational teams. Allowing a system of matrix teams that can deliver tailored care to specific populations and local health needs. This means combining clinical and non-clinical expertise including community connectors/ social prescribers (or equivalent) in partnership with the expert generalist GPs and a diversity of wider expertise as needed.

Primary care in ten years' time

Our vision for 2035

For citizens

- Access to convenient, high-quality healthcare services.
- Clear pathways to appropriate care.
- Personalised and coordinated care for complex conditions.

For primary care

- Greater autonomy in commissioning and service delivery.
- Leadership in integrated neighbourhood health teams.
- Improved digital and IT infrastructure to support service efficiency.
- Greater and more efficient capital investment and flexibility, allowing the most efficient part of the Health Service to continue to innovate.

In the sections that follow, we consider what is needed to achieve this ambition.

Access

The access crisis is rooted in rising demand, variation in service provision, pressures in the rest of the system and mismatched expectations. In part, increased complexity has driven rising demand, with one in four adults living with two or more long-term conditions. The population over 85 – the cohort most likely to be living with multiple long-term conditions – is set to almost double by 2045.[6,7]

Yet policy solutions have so far failed to address the factors affecting access, treating access as a single issue and predominantly targeting increased appointment numbers, especially face-to-face. As a result, continuity of care has been eroded, resulting in lower patient satisfaction and a volume-focused approach to accessing primary care rather than a quality and outcomes-focused approach.[8]

Relying on targets to ease access challenges fails to reflect the complex connections that make up access needs and, if not implemented as part of wider strategic changes, serve no purpose. Measures that tackle access as an outcome of several factors must be adopted as part of long-term sustainability measures.

How primary care is responding

Primary care is already leveraging a range of resources to improve access. Our members have responded to the crisis by adopting virtual triage, expanding their workforce through use of the ARRS and offering services beyond the GP appointment. In many areas of the country, members have partnered with secondary care providers to co-locate in A&E to tackle system-wide access challenges, while others have developed PCN hubs and urgent treatment centres. Despite these efforts, demand continues to outstrip capacity in many areas and the pace of growth is a developing concern.

Shifting the dial

Short-term actions to stabilise primary care

- NHS England should shift to outcomes-focused measures and continuity of care rather than measuring activity. This could include focusing on the impact of repeat presentations across providers for patients with long-term conditions who benefit most from continuity.
- Prioritise the creation of a single shared patient record, supported by interoperable IT systems commissioned at scale.[9]
- Providers should be supported with the resource to conduct risk stratification, supported by an accredited AI triage system that ensures patients see the right practitioner every time.
- Commission local services across primary care to support health checks, vaccinations, immunisations and screening.
- Integrated neighbourhood teams should roll out bespoke health literacy programmes for their areas based on locally identified needs.

Long-term actions

- Review the effectiveness of the NHS 111 algorithms and develop a system with primary care at scale with greater capacity to manage risk and improve continuity and patient experience.
- Incentivise primary care providers to improve outcomes for high-risk patient groups, shifting the focus away from the volume of activity to the quality of activity.

Funding and contracts

Years of underinvestment have left primary care with inadequate resources to meet demand. The Nuffield Trust found that funding for general practice has lagged behind other NHS sectors, disproportionately impacting deprived areas.[10]

As the King's Fund highlighted, the traditional GP partnership model is becoming increasingly unsustainable, with a drop from 74 per cent of GPs in partnerships in 2015 to 57 per cent in 2022.[11] The current funding approach is a low-trust, high-risk model. It is designed around the small minority of independent primary care contractors who deliver poor services and operate in an opaque and obscure manner.

These challenges are echoed in wider primary care, with reduced availability of NHS dental services being driven by a broken units of dental activity (UDA) model that ensures that the dental budget is regularly underspent and patients cannot access vital dental care. The inflexibility of the current contract limits the economic viability of NHS dentistry and ultimately pushes more NHS dentists to withdraw NHS services.

Similarly, community pharmacies have been shutting down at an alarming rate, with funding for community pharmacies decreasing by over 30 per cent in real terms since 2015. National drug tariffs often fail to reflect the real cost of dispensing. In optometry, key figures report flat sales and rising expenses, while increases in National Insurance and minimum wage have been key concerns for budgets going into 2025.

Measuring progress of the shift from hospital to community

At present our health and care system has an operating model focused on late-stage interventions rather than upstream interventions focusing on preventing ill-health. This approach holds back primary care, places a greater burden on system resources and does not deliver the best outcomes for patients.

The Labour Party's Health Mission recognised this, noting that "we spend more money on hospital care relative to community-based prevention than any other European country. The front door to the NHS is suffering because primary care is overwhelmed and inaccessible and the back door of the NHS – the discharge of patients from hospitals – is blocked by an inadequate and neglected social care system. The status quo is bad for patients, and unnecessarily expensive for the taxpayer."[11]

The shift of resources out of acute settings and into primary and community services forms one of the government's three 'big shifts' at the heart of the upcoming ten-year health plan. This responds to the Darzi review's criticism of 'right-drift', by which the proportion of the NHS budget which is committed to acute care in hospitals has grown since 2006: the inverse of its stated left-shift strategy.

Success in the shift from hospital to community will require a metric to measure progress and inform local course correction. Therefore, the DHSC should agree with local ICS a metric for the shift of care closer to home to help national and system leaders assess and report on progress. This should not undermine local autonomy but be used as a tool to inform ICSs' decision-making and responsibility for delivering on the government shift from hospital to community.

The NHS Confederation will produce a menu of available options to measure the shift that align with devolution systems and greater local autonomy.

Shifting the dial

Short-term action to stabilise primary care

- Increase the percentage share of NHS budget allocated to primary and community services. Agree, with local systems, a metric for the shift to care closer to home to help national and system leaders assess and report on progress. This should not undermine local autonomy but be used as a tool to inform ICSs' decision-making and responsibility for delivering on the government shift from hospital to community.
- DHSC should work with ICSs to agree on a metric for the shift of care closer to home to help national and system leaders assess and report on progress.
- Remove short-term instability with multi-year budgets for locally commissioned services and vital infrastructure improvements.
- Commission a review of the Carr-Hill formula to better address deprivation and rurality issues, informed by the work in Leicester, Leicestershire, and Rutland (LLR) and Frimley.
- Support the development and commissioning of primary care at-scale providers (primary care provider collaboratives) to provide additional services such as urgent treatment services, diagnostics and day surgery, with greater involvement in ICS elective reform plans.
- Reform GMS regulations to allow limited liability partnerships (LLPs) to hold contracts and update NHS pension regulations to allow LLP partners to contribute to the NHS Pension Scheme. This step will enable general practitioners to limit their individual liability or risk associated with the business. This structure is commonly used in other partnership models e.g. the legal profession.
- Improve the ease of access for at-scale primary care providers to access the NHS Pensions Scheme, improving clarity and guidance for these organisations.

- Prioritise reforms in the dental contract to overhaul the use of units of dental activity to incentivise improvements to patient outcomes over volume of activity.
- Ensure a new community pharmacy contract sufficiently renumerates activity and medicine costs, and recognises the skills and capabilities that exist, enabling pharmacists to work at the top of their licence. This will unlock innovation and much-needed system capacity.
- Commission enhanced services from audiology and optometry providers to reduce the burden in secondary care.

Long-term actions

- Create population cohort-based place-level budgets that can support the delivery of community-led services at a neighbourhood level, supported by a strong place-based integrator vehicle.
- As recommended in our response to the incentive consultation, DHSC and NHS England should develop a streamlined list of national general practice incentives with greater autonomy for local leaders to layer incentives with a menu of local priority indicators.[12]
- Reform Section 75 of the NHS Act to enable greater integration and pooled budgets across providers. This would involve allowing a greater scope of organisations that can pool budgets and greater scope for services provided.
- Provide primary care collaboratives with greater autonomy and flexibility in organising and delivering services across neighbourhood, place and system levels.
- Replace traditional practice and neighbourhood-level reporting with a consolidated reporting system to a locally agreed at-scale provider, aligned with an agreed maturity matrix.

- Offer long-term contracts to primary and community providers for outpatient services, such as diagnostics, to secure stability and capacity. For example, consider the national roll-out of community and minor eye care services and audiology pathways for adult-onset hearing loss.

Workforce

Like access, workforce has often been presented as a single-issue challenge which can be addressed with more staff. Some measures introduced to expand the workforce, including the ARRS, have had a positive impact. However, there are still issues around shortages in shared workforce pools, two-tiered pay and benefits systems, and central control over the number and type of roles available.[13]

Moreover, the challenge of housing additional staff in unsuitable estates, paying increases in Employers' National Insurance and pay awards out of core income has resulted in providers across the spectrum of primary care choosing between cutting staff and services and balancing demand.

The current challenge in recruiting and retaining the GP Workforce is impacting patient satisfaction. Data shows that practices with a smaller number of patients per general practitioner experience higher levels of patient satisfaction.[14]

In general practice, the current landscape is negatively impacting existing partners' experience and creating financial barriers to newly qualified GPs buying into the partnership model. Without addressing the barriers to future GP workforce, the sector risks collapse.

How primary care is responding

While issues like funding and benefits are managed by policy setters, our members have been concentrating on what they can achieve to stabilise their own workforce. The needs of the workforce are changing, with greater interest in portfolio working and the emergence of leadership beyond the practice - at neighbourhood, place and system levels. These needs are shared with operational staff and non-clinical leaders, who are underrepresented in workforce planning. Our members are currently prioritising retention and attracting new staff to balance high turnover and high demand. Further support to deliver education and placements to young people and newly qualified staff is seen as vital to ensuring the continued survival of the sector.

Shifting the dial

Short-term actions to stabilise primary care

- Resource provision for clinical supervision, retention and development.
- Remove all role caps associated with the ARRS, allowing primary care networks to recruit the skill mix appropriate for their population.
- As part of the refresh of the workforce plan, review skill mixes in primary care, addressing shortages in specialised digital and technology workforce skills, mental health, pharmacy and relational continuity roles.
- Prioritise the retention and recruitment of expert generalists in the workforce plan, creating greater stability and security for the next generation of general practitioners.
- Prioritise supporting a growth in placements for staff groups where a shortage has been identified, including non-clinical support and leadership roles which will facilitate the development of the infrastructure for neighbourhood working.

- Deliver contractual parity for roles in primary care with their equivalents in other NHS organisations, enabled by sufficient central funding.

Long-term actions

- Primary care workforce development should be included in ICS's improvement strategy. Leadership training should be prioritised for staff expected to take on leadership positions in neighbourhood teams, place-based integrator functions or system-based provider collaboratives.
- Leadership development should be included in the career pathway for every role, including operational delivery, clinical and non-clinical practitioners. The shift to developing teams of teams increases opportunities for supervision, mentoring and management at different scales.

Infrastructure

As highlighted by previous actions from the centre on access, funding and workforce, infrastructure is the vital lever which enables effective change. Efforts to increase appointments and staffing have increasingly been restricted by the shortage of suitable estates and the need to support growth and demand in digital tools through investment.

How primary care is responding

Member engagement on infrastructure identified examples of innovative estates solutions, including purpose built multi-provider hubs and renting unused city centre spaces. These solutions expand the space available to house staff and see patients, as well as supporting care close to home. However, each comes with its own challenges, from scarcity of funding for development to the long-term costs of high rents.

Most members are working creatively in the space they have. Some are embracing hot desking for consultation rooms, hybrid working to maximise office space, and hosting ARRS staff in premises owned by other providers. These solutions have improved the space available, but members agree that they are insufficient to support further growth and can have a negative impact on collaboration.

A long-term solution to estates development will be crucial to ensuring the sector is able to provide care. One potential solution is the growth in neighbourhood hubs, which enable co-location of services beyond health. These hubs, as with any infrastructure solution, must be supported by an increase in integrated, interoperable technology, essential for efficient, patient-centred care. Members agreed that a reformed approach to data sharing standards and investments in digital and technology infrastructure can unlock new efficiencies and support innovation, aligning with modern care delivery needs. The current level of risk faced by individual practices as a 'data controller' is unsustainable, leaving individual practices subject to the risk of significant ICO fines that could be detrimental to their viability as small businesses.[15]

Shifting the dial

Short-term actions to stabilise primary care

- Accelerate read and write access between all electronic patient record (EPR) systems with expansion of schemes such as GP Connect.
- Provided accelerated support for the Tech Innovation Framework, allowing new EPR providers to disrupt the market with innovative technology.
- Focus on enabling effective data sharing interoperability within and between NHS organisations and consider both the potential and the implications for the Federated Data Platform (FDP) for primary care and beyond.
- Ensure a shared patient record system supports integrated care, removes silos and leverages AI for population health management and coordination.
- Develop a national health planning standard based on the Healthy Urban Development Unit Model to ensure health is better represented in all new development projects.[16]
- Prioritise the development of new hub health centres with greater system flexibility for accessing capital funding.[17]

Long-term actions

- Create a shared-ownership model for primary and community data that removes the sole data controller responsibility from general practice. This should be grounded in improving data-sharing and reducing the administrative burden and risk placed on individual GP practices.
- Create a hub-and-spoke model for primary and community premises.
- Address the disconnect between commissioning services and NHS estate ownership by gradually transferring the

responsibility of DHSC Property Company owned primary and community premises to ICSs, driving use of void space.

- Establish joint decision-making committees between community health partnerships (CHP) and ICSs to assess the value for money of purchasing the NHS Local Improvement Finance Trust (LIFT) estate at the end of the finance agreement. If purchased, these premises should transfer to the ICB, with a new lease agreement agreed between existing NHS provider tenants and the ICB. Over time, as LIFT agreements expire and the estate transfers to ICBs, community health partnerships' role should be reviewed.
- Review the role of NHS Property Services and consider its abolition, moving its assets to ICBs and splitting its functions and budgets between ICBs and NHS England..
- Review the current notional rent model used in general practice, learning from successful index-linked models used in other comparable countries.
- ICSs should have a greater role in owning, leasing and managing primary and community premises, recoupling commissioning and estates provision.

Exploring the art of the possible

Across the world, healthcare systems are pivoting towards outcome-based community-led interventions to face the growing challenge of an ageing population with multi-morbidities. We believe the NHS can learn from some of the challenges and accomplishments of countries such as Italy and Ireland, which have been able to strategically combine investment with reform. While there are significant differences between the healthcare systems, it is vital that we take the best of the rest to the NHS.

Sláintecare: Enhanced Community Care Programme (Republic of Ireland)[18]

Ireland's Health Service Executive (HSE) has reported significant progress in reducing hospital admissions and attendances through its Enhanced Community Care (ECC) Programme, a key component of the Sláintecare reform strategy to deliver healthcare closer to home. The ECC is focused on increasing the provision of community health services while simultaneously reducing pressure and demand on hospital services. The programme has seen the introduction of specialist integrated teams for older people and disease specific specialist teams.

It has reduced hospital attendance and admissions by enhancing primary and community-based services. This approach has improved patient outcomes, particularly for those with chronic diseases and older adults, by providing timely diagnostics and integrated care closer to home.

Outcomes

- **Chronic disease management**: 91 per cent of patients with chronic diseases are now fully managed in primary care via the Chronic Disease Management in General Practice Programme.

Between January and July 2023, GPs reviewed 309,778 patients under this programme.

- **Community diagnostics**: Community diagnostics teams conducted 196,988 radiology scans from January to July 2023, with projections to surpass the 253,172 scans performed in 2022. Timely access to diagnostics has led to an 89 per cent reduction in patients requiring referral to emergency departments or acute medical units.
- **Support for older people**: In the first seven months of 2023, teams supporting older individuals contacted 48,230 patients, with 64 per cent discharged home, thereby avoiding potential hospital admissions.
- **Staffing investments**: The ECC Programme has secured over 78 per cent (2,733.2 whole-time equivalents) of the planned full-time staff, including community health network managers, assistant directors of public health nursing, general practitioner leads, and consultants for integrated care programmes.

The ECC Programme exemplifies the Republic of Ireland's commitment to transforming healthcare delivery by emphasising community-based care. The programme alleviates pressure on hospitals and enhances patient wellbeing by managing chronic diseases within primary care, expanding diagnostic services, and supporting older individuals at home. Ongoing investments in primary and community care staffing and infrastructure are crucial to sustaining this model.

Italian Community Healthcare Reform

In 2022, the Italian health system introduced a transformative reform under Ministerial Decree 77/2022 as part of the EU-funded Recovery and Resilience Programme. This reform aimed to enhance community healthcare by creating integrated health and social care services closer to where people live. It sought to modernise general practitioners' roles while establishing a robust network of community care centres and smaller spoke facilities to deliver accessible, non-emergency care.

Outcomes

- A modernised, integrated care delivery model focused on community healthcare.
- Improved accessibility to non-emergency services for residents across Italy.
- Enhanced support for GPs, providing a pathway for transitioning into integrated care without compromising independence.

Key features

Integrated Community Care Network

- Establishment of **community care centres**: One per 50,000 residents, offering primary care, prevention, maternity services, diagnostics, and specialist consultations.
- **Staffing**: Doctors available 24/7 and nurses 12 hours daily, seven days a week.
- Smaller **spoke sites** offering GP, nursing, and specialist services open 12 hours a day, six to seven days a week.

Domiciliary and social care integration

- Services designed to integrate health and social care, improving accessibility for patients in their local areas.

GP contractual reform

- Newly qualified GPs must spend part of their working week at integrated care centres, with hours proportional to their registered patient list size.
- Existing GPs can work in the new centres, maintaining their independent contractor status.
- Modernised health centres owned and managed by local health authorities provide stability and security for GPs while enabling phased adoption of the new model.

Modernising GP roles

- Addressing the declining appeal of independent contractor status by offering flexibility and support through the new centres.

The Italian Community Health Reform represents a significant step toward modernising healthcare delivery by creating integrated community care services. The balance between maintaining GPs' independent contractor status and fostering collaboration within new community centres exemplifies a progressive approach to healthcare transformation. The reform ensures improved access to quality care for residents while addressing workforce challenges in general practice.

Conclusion

The future of primary care requires a strategic shift that prioritises accessibility, innovation, and community-centred solutions. Based on insights from our members, we have developed a vision that aims to stabilise and transform primary care.

Our vision is to reform primary care, making it the most proactive, personalised and technologically advanced health care system. Building on its strong foundations, it would support citizens to engage in their care, ensure improved, equitable health outcomes for all and deliver a supported, connected workforce that has the resources to enable delivery of high-quality care. It would play a crucial role in putting the NHS as whole back on its feet and on a financially sustainable footing.

This modern, empowered, sustainable primary care system will be proactive, patient centred, integrated, and data informed. It will be committed to ensuring access and continuity through collaboration and workforce development, using resources sustainably and equitably and at a scale that optimises benefit. Our multi-professional workforce will be integrated and connected and supported to develop leadership and skills for continuous learning and development.

Currently, we see short-term fixes for long-term problems, but our members have expressed a need for resources that allow them to return to long-term planning. By leveraging the capacity and skills within primary care, we can put primary care on the best footing to drive a relational model of care at the heart of a neighbourhood health service; a model which secures the future of the NHS and is led by those best positioned to drive it: the frontline.

A locally led and designed neighbourhood health service will facilitate a radical shift towards community and preventive care, enabling the NHS to transition from a *reactive* to a *proactive* care model. Maximising the impact of

out-of-hospital providers and the voluntary, community and social enterprise (VSCE) sector, which significantly influence the broader determinants of health.

To achieve this, the NHS must actively work with strong primary care leaders and support the development of a workforce prepared for collaboration from the beginning of their careers. These leaders will shape local networks and benefit from improved infrastructure through primary care provider collaboratives, ensuring they have a voice at system level and that decision-making is equitable across all sectors of the NHS.

This vision calls for bold, ambitious reform, strategic investment and a steadfast commitment to collaboration, equity and innovation, driven by greater accountability to system partners and patients. This is about shifting the balance of accountability from just upwards accountability to government and NHS England to outwards to community partners, patients and local authorities.

With this commitment, in ten years, primary care should be a seamless, integrated component of the healthcare system – more accessible to communities and responsive to their dynamic needs. Most importantly, in ten years, primary care will still be here, delivering for patients.

If our recommendations are implemented, the government can take steps to stabilise and transform primary care over the next ten years. Implementing our primary and community focused interventions will help shift the focus of national teams and system leaders to the services that deliver care closest to the patient's door. The government should take inspiration from other large health systems in Italy and Ireland that have undertaken large-scale primary and community services reforms.

One critical factor that the government must address in the ten-year health plan is the level of risk currently held by independent contractors in primary care. By working with members, we have identified several practical recommendations that can help to modernise the partnership model for the next generation of GPs. This collaborative approach ensures that all stakeholders are part of the solution, harnessing and developing the potential of at-scale primary care organisations.

Greater scope for delivering new integrated health hubs that provide additional services such as out-of-hours care, urgent treatment services, day surgery, and diagnostics can invigorate neighbourhood and place-based primary care organisations. This will not only improve the efficiency of the healthcare system but also enhance the patient experience. Creating hub sites will further support and empower hyperlocal spoke sites to deliver integrated relational continuity to patients.

Empowering primary care at scale can reduce failure demand and the fragmentation of out-of-hospital care with place, and system-based primary care organisations acting as integrator anchors can support individual practices while providing a greater range of integrated health services at scale. Patients often have to navigate different care pathways dependent on the time of day they require care; by harnessing the ability of primary care at scale, we can remove inefficiency and bureaucracy of the out-of-hours model and provide patients with an efficient front-door for their care available 24/7.

By supporting the growth and development of place and system-based primary care organisations, we can move from a volume-focused access model to an outcomes-focused approach. Place and system-level providers are well-situated to take greater responsibility for patient cohorts, working across the primary care family, community services and VSCE partners to deliver personalised neighbourhood-level care while providing expert analysis and integration support.

DHSC and NHS England can work to increase investment, autonomy and flexibility for primary and community care services nationwide, enabling the move towards a neighbourhood health service. It is time to recognise, reward, and empower the organisations Lord Darzi described as having the best financial discipline in the health service family.

Appendix 1: engagement with patient groups

The Primary Care Network, in partnership with Healthwatch England, convened a focus group of eight Healthwatch organisations from different regions in England, representing a mix of urban, rural, coastal and diverse socioeconomic areas. The group met online on 1 August 2024 to discuss the future of primary care, focusing on three main topics: location of services, access to services and data-related issues.

- **Co-location of services** (combining different healthcare providers in one location): This can lead to the closure of local services, which concerns communities. Access to healthcare is more important than building quality for many people, especially in rural areas where new sites can be far from residents.
- **Premises**: Older buildings often cannot accommodate modern healthcare needs (such as for accessibility or new roles in primary care). Newer buildings can be costly to rent, limiting the potential for community organisations or complementary services to be located there.
- **Transportation**: Rural areas are poorly served by public transport, and even in urban settings, bus routes may not be efficient for accessing healthcare. Poor transport links exacerbate difficulties in accessing services in rural areas, with reliance on cars and limited parking also common concerns.
- **New healthcare services in the community**: Patients often do not know about new healthcare services available at GP practices, such as musculoskeletal or mental health services. Clear communication is needed to improve awareness and use of these services.
- **Dental and pharmacy access**: Access to dental services remains a significant issue, worsened by closures and limited

availability. Similarly, pharmacy closures and restricted opening hours hinder the use of services like Pharmacy First.

- **Continuity of care**: Patients value continuity, preferring to see the same healthcare provider to avoid repeating their medical history. However, complex patients, especially older adults, often experience fragmented care.
- **Data and related issues**: Data sharing between healthcare services is generally accepted as long as it improves service delivery. Patients are frustrated by having to repeat their medical histories across different services. However, inconsistencies between systems in different regions can make data sharing difficult. While most patients are comfortable sharing data, concerns arise when data is not shared effectively or accurately, particularly when hospital clinicians lack information from GPs.

Discussion

During the discussions, we heard a range of views. Though we shaped the discussion around location, access and data, some cross-cutting themes and experiences existed.

One key point was the importance of clear communication and, if possible, partnership with local people when deciding how to plan and locate services. On paper, it might seem that the current state of buildings and services are not well suited to current needs. However, when existing services close and new ones re-open further away or consolidate existing sites, this can mean a perception of reduced access. New buildings do not always live up to the promise for local people; they can be costly to rent for new and complementary services to locate in.

Another important issue raised was the need for a better understanding of new, emerging and complementary healthcare professionals that people might be able to see. People may access healthcare professionals and services at their regular GP practice but do not realise services such as musculoskeletal or mental health, are available.

Finally, an essential aspect of the future of primary care across GPs, dentists and pharmacists is how these services respond to growing demands for access. Demand for healthcare appointments has been increasing, and people have often become frustrated with difficulty seeing the service they want. Internet-based technology such as digital appointment booking, accessible online information on which dentists are taking NHS patients, and up-to-date opening times can help support people's choices and access in managing their health on their own terms. There is a need to match the provision of services with where people live, where population demand is increasing, and where people can access easily by car and public transport, if possible.

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