



Community
NETWORK

Primary care networks: a quiet revolution

**A guide for provider organisations
on how to engage effectively with PCNs**

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Introduction

Primary care networks (PCNs) were the big innovation in the NHS England long term plan when it was published at the start of 2019.

The purpose of PCNs is clear in the title of the first section of Chapter 1, “we will finally dissolve the historic divide between primary and community health services”, and they have been designed to help achieve a series of goals from addressing profound challenges in general practice to acting as the building blocks on which integrated care systems (ICSs) will function successfully.

While there is recognition in NHS England/Improvement that PCNs are not the answer to everything, and can't be given too much to do too quickly, it is clear that they are now expected to be the principal mechanism to achieve changes in how neighbourhood-level health and care will be delivered across the country.

Once the dust settles, there will be roughly 1,260 PCNs across the country.

Given that PCNs aim to manifestly impact the way that the whole population experiences local health and care delivery over the next five years, you would be forgiven for thinking this revolution has been relatively quiet to date. As the speed of change ramps up over coming months however, it is unlikely to stay that way.

This briefing paper sets out in 11 chapters the essential knowledge that providers should have on PCNs, including:

- Where PCNs came from.
- What PCNs are (and what they're not).
- What outcomes PCNs will deliver.
- What has it taken to get PCNs set up.
- What role do clinical commissioning groups (CCGs) and local medical committees (LMCs) have.
- What new funding and support is available.
- What the emerging picture is.
- What the next nine months holds.
- What happens after April 2020.
- Given all of that, what role should providers play around PCNs.
- Case studies and examples of supporting offers.

The paper draws on published guidance, discussions with PCN leaders in NHS England/Improvement and discussions with providers of community services (including acute trusts, mental health trusts, integrated trusts, community trusts and large-scale social enterprise community providers). Each chapter highlights what is most relevant to help those providers to engage with PCNs.

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Where did PCNs come from?

PCNs were formally established across England from 1 July 2019. Year one will be a period of critical importance to their future effectiveness, and with that the success of integration in local systems. It is vital that providers and PCNs work together in the first nine months to get this right.

To that end, it is helpful for providers to be clear on how PCNs came about. There are multiple drivers behind their creation, including:

- a desire to **protect the long-term sustainability of the general practice model** (Simon Stevens' often quoted line, "If general practice fails the NHS fails")
- the need for a mechanism that works with the fragmented and quasi-independent nature of primary care and general practice, and brings them **consistently and coherently around the table to support integration** of local health systems
- the need to ensure **stronger and more consistent collaboration between primary and community care** to deliver services in a more seamless way for patients
- an ambition to support the local **take up of population health management** to deliver patient care in a targeted way that is increasingly critical to managing demand and cost
- a desire to support the **roll-out at scale of learnings from NHS England vanguard programmes**, as well as lessons from other local areas where coordinated health and care delivery is proving a success (particularly the National Association of Primary Care's primary care home sites)
- a recognition of the need to **channel additional investment** into primary and community-level services to support their capacity to deliver out of hospital care
- the requirement to be able to **hold organisations to account** for the effective use of that additional funding.

Understanding the breadth of these ambitions explains the scale of change PCNs are attempting to bring about. It also helps shed light on why different groups in the system risk taking different priorities away from PCNs.

2 What is a PCN (and what is it not)?

A PCN is one or more general practices working together with a range of local providers to offer coordinated health and care services to a defined patient population of typically between 30,000 and 50,000.

There are seven essential characteristics that PCNs are expected to have that are helpful for providers to bear in mind. These are helpful not just because they are vital to the success of PCNs, but also because it is where some nascent PCNs are failing to demonstrate these characteristics that providers are already experiencing challenges.

More than just GPs

While PCNs are being established through the new five-year GP contract they are **not** intended to be closed networks. PCNs should be an extension of the existing independent GP partnership model, although, critically, a successful PCN will be one that enables general practices to work hand in glove with any and all local providers relevant to their neighbourhoods.

The latest FAQs document¹ published by NHS England/Improvement is clear that PCNs are **expected to have wide-reaching membership**, including primary care, community services, community pharmacy, optometrists, dental providers, social care providers, voluntary sector organisations and local government.

Function over form

These are networks **not** new structures, new organisations, commissioning bodies or a new NHS management tier. In some instances, a PCN might decide it would like to operate through a new organisation, but the focus should be on getting as quickly as possible to more joined-up local delivery for patients.

NHS England/Improvement is agnostic on what the precise local set up arrangements should be; in part because they have been told they are often overly prescriptive and fail to allow room for local areas to just run with what works, and partly because they wanted this to happen quickly and not lose time and money upfront to get set up. Where possible the hope is to build on arrangements that are already established and working.

Focused around sensible neighbourhoods

PCNs are expected to have boundaries that make sense to the practices in the network, to other community-based providers and to the neighbourhoods they are set up to support and typically not cut across existing CCG, sustainability and transformation partnership (STP) or ICS boundaries. PCN neighbourhoods should contain a defined population of between 30,000 and 50,000; though allowances have been made for some reasonable movement above and below those numbers.

This point about serving natural local communities that geographically make sense is critical to current providers of community services who from 1 July will be required by the NHS standard

1 <https://www.england.nhs.uk/primary-care/primary-care-networks/pcn-faqs>

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contract to configure their teams around PCN footprints (not least in areas where those community teams are already working around specific geographies). This has proven a difficult balancing act between having strong enough bonds of affiliation between practices that they can work effectively together, but also work on sufficient scale with community partners on a sensible geography.

Another issue occurs when a new PCN boundary cuts across previously agreed working boundaries – particularly when providers of community services have already reconfigured to align with what has previously been agreed.

Brand new building blocks for integration

PCNs are a new addition to the local integration landscape. They are **not** designed to replace anything that already exists, **nor** to force existing providers to relinquish activities they currently deliver. Rather they are intended to be a mechanism to ensure that primary, community and social care work together as effectively as possible. This is a direct response to ICSs and STPs saying they cannot transfer care out of hospitals without better integration at the community-level.

In the eyes of NHS England/Improvement, PCNs are now a critical delivery layer in a schematic that starts with the individual and builds through neighbourhoods to place (circa 250,000-500,000 population) and system (circa 1 million population). PCNs drive integrated working at the neighbourhood level, but will ultimately need to align seamlessly with arrangements at place and system levels. PCNs must be designed therefore to meet specific local needs and operate in a consistent fashion.

Collaborate to be sustainable

PCNs not only aim to improve joined-up care for patients, they require collaborative working because without it the system will fail to be sustainable. Not only is integrated working at a neighbourhood level critical to taking activity out of acute settings, it should avoid duplication of work and workforce and drive innovation between primary, community and social care providers.

By introducing a mechanism that requires non-siloed thinking, supported by new funding, PCNs try to ensure best use of collective resources and a more sustainable workload spread across a range of providers. Finally, that resilience is underscored by the mandate that all practices in a PCN will share relevant data with one another and use a population health management approach to ensure their efforts are targeted as effectively as possible on prevention and supporting the highest risk (and typically most expensive) individuals in their local population.

Channel to drive learning and best practice

PCNs are the mechanism by which NHS England/Improvement will scale up the learnings they have gained from the vanguard sites, and from grassroots innovations such as the National Association of Primary Care's primary care home model. PCNs will be accountable for implementing a series of national service specifications that will roll out newly established best practice. This is important because these new ways of working cannot for the most part be delivered without collaboration with community service providers.

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Accountable performance improvement

With money comes accountability. The investment of new funding at a faster rate than the rest of the system comes with the mandate that each PCN has a named and accountable clinical director (who does not have to be a GP) and a named organisation which holds a bank account to receive the funding (which does not have to be a general practice).

PCNs will be accountable to CCGs for meeting their contract terms; terms that will evolve every year as new specifications and responsibilities fall into place. PCNs will be expected to capture data against particular metrics, track warranted and unwarranted variation across practices, account for their performance from April 2020 and drive continuous improvement.

3 What's the prize?

For PCNs to be successful it will be important for everyone involved in the successful delivery of PCNs (including non-GP providers) to have eyes on the collective prize from the off. The outcomes that will make their efforts worthwhile include:

For patients

- better, more personalised health and care services, delivered more conveniently in settings closer to home
- support for individuals with more complex conditions that is better coordinated across different health and care services
- stronger support for patients to play a much greater role in making safe and informed decisions about their own health and care, taking full advantage of all local resources.

For providers

- funding and central support to build greater capacity and resilience (including up to 20,000 new staff over the next five years)
- greater stability and a happier workforce courtesy of a more sustainable approach to staffing, with more manageable workloads and more professional development opportunities through multi-disciplinary team working
- the opportunity to have future funding aligned to savings achieved through local integration.

For the system

- a critical enabler to driving the triple integration of primary and community care, physical and mental health services, and health and social care
- opportunity to drive up consistency in quality and outcomes across health and care at a neighbourhood level across the country
- increased focus on prevention, self-care and population health management informing better targeted clinical interventions and keeping people out of hospital, which in turn drives the sustainability of the system and reduces health inequalities.

Specifically, by 2023/24, NHS England/Improvement's ambition is that PCNs will have²...

- 1 Stabilised the GP partnership model.
- 2 Addressed the capacity gap at a community-level and improved the diversity of skills through 20,000 additional staff.
- 3 Become a proven platform for channelling central funding into local systems at a neighbourhood level, including into premises.
- 4 Dissolved the current divide between primary and community services.
- 5 From those, delivered a quantifiable impact for patients and the wider NHS, including proving that investment in primary and community can help moderate demand on A&E, reduce spend and improve patient experience and outcomes in the rest of the system.

2 <https://www.england.nhs.uk/publication/nhs-england-and-nhs-improvement-board-meetings-in-common-agenda-and-papers-27-june-2019>

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Getting up and running

It is important for providers to understand what is being asked of PCNs to get themselves set up and established, because:

- While the deadline for legal establishment was 1 July 2019 (after which composition of practices and geographies are unlikely to change), **PCNs will continue to evolve ways of working in collaboration with local providers** as they mature.
- There are **various roles non-GP providers can and will play** in supporting those ways of working (from mandatory requirements such as delivery through integrated teams, to optional arrangements in areas like workforce recruitment and population health analytics).

It is also helpful for providers to understand the scale of effort required because it helps explain why in many areas GPs have stepped back from ongoing dialogue about system-wide integration to focus temporarily on getting PCNs legally in place and get the new funding flowing. This is causing problems in some parts of the country but should be manageable provided the pause is genuinely temporary and the will to collaborate remains intact.

Initial submissions to NHS England/Improvement: getting over the line

By 15 May 2019 incipient PCNs were required to make their initial submissions to NHS England/Improvement, including which practices would be members, the combined list size of the network, a map showing the agreed geography and a copy of the initial network agreement signed by all members (see below).

By June 30 every practice should have signed up to a fully completed PCN network agreement capturing how each PCN will handle network-specific activity. This will sit alongside a five-year network contract direct enhanced service (DES), an extension of the core GP contract, which each practice will need to sign by the same date to ensure they receive funding for taking part in a specific PCN.

The aim was that by 1 July 2019 every PCN is established, with every practice signed up, achieving 100% coverage across the country.

The network agreement: establishing the PCN foundations

The network agreement will establish the foundations for each PCN. It includes national terms expressed as mandatory clauses, which cannot be changed but can quite often be supplemented; and empty schedules that allow for every PCN to specify local arrangements around specific types of activity.

Network agreements, are in a number of critical ways, very deliberately not set in stone. Any of the national terms are subject to variation in agreement between the British Medical Association (BMA) and NHS Commissioning Board. Importantly for providers though, the documents will also be updated year-on-year as working arrangements evolve and new services and funding come on line.

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It is critical to understand that practices have considerable control here: provided all practices have signed up, CCGs cannot challenge the content of network agreements, and member practices can leave or join PCNs without needing to seek CCG permission.

In their first iteration, the network agreements capture a number of choices that the PCNs have made around ways of working and models of operation which can be helpfully put into five categories:

- 1 Governance and decision-making arrangements
- 2 New roles and employment arrangements
- 3 New funding arrangements
- 4 Management and back office support arrangements
- 5 New service delivery arrangements

PCNs have been given a clear steer not to focus on creating new legal structures in the first instance, though some may choose to go down that route. Beyond this, NHS England/Improvement has fought to remain agnostic on the question of any preferred operating model for PCNs.

The operating model that emerges in each case will depend on choices made under the headings above, particularly on the identity of the authorised organisation that will receive funding and distribute it to PCN members, and arrangements around employing new staff.

1 Governance and decision-making arrangements

Every PCN must evidence that it has robust and appropriate organisational and clinical governance arrangements in place. This includes:

- Setting up a board to act as a governing body;
- Agreeing rules around decision-making processes, practice representation, voting rights, meetings and quorum requirements, selection of a chair, appointment processes, terms of reference, dispute resolution procedures;
- Agreeing clear lines of accountability – from clinical directors back to the board, from the board to member practices, between practices for delivering shared responsibilities, and from PCNs back up to NHS England/Improvement for delivering agreed outcomes.

2 New roles and employment arrangements

PCNs need to create multi-disciplinary teams (MDTs) to deliver a more joined-up offer to patients. In many places, these teams already exist (potentially under different names). The critical points for providers to know here are:

- The starting point is that organisations will retain responsibility for their existing staff, while new arrangements need to be agreed for the employment of new staff;
- Every PCN must have appointed a clinical director in order to go live by 1 July 2019; While the role requirements are outlined in the DES, PCNs can add to those to develop their

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own role descriptions.

- Over upcoming years, PCNs will deploy five roles that will be partly or wholly reimbursed through central funding, including: clinical pharmacists (2019), social prescribing link workers (2019), physician associates (2020), first contact physiotherapists (2020) and first contact community paramedics (2021);
- New staff will be embedded in practices, working in MDTs, with agreed role descriptions. They can be employed by PCN member practices, or another body (e.g. other health or care providers, GP Federations, local authorities or third sector organisations);
- Staff need to be well managed, appropriately supported in their professional roles, and have access to admin support;
- Who will carry the employment costs and liabilities should be captured in schedule 5 of the network agreements, and will reflect the PCN choice of operating model (e.g. employment spread across multiple practices, held by a lead practice, or employed by a non-GP partner and seconded in).

To access funding, PCNs must demonstrate new staff are in addition to the existing workforce (numbers will be baselined up front to prevent commissioners using new funding as an excuse to cut staff anywhere else). These staff are additional to the extra nurses and GPs that will be funded through increases in the core GP contract.

The aim is to grow additional capacity by creating up to 20,000 new roles over the next five years. This is meant to help address national workforce shortages, and not to fill existing vacancies or subsidise posts that already exist.

3 New funding arrangements

To go live, PCNs must have identified an authorised organisation to receive and distribute funding on behalf of the network. Initially the assumption was that would have to be a PCN member practice, but NHS England have clarified that other local providers who hold a primary medical care contract can carry out this role (including GP Federations).

How funding is distributed within a PCN will depend on the choice of operating model (i.e. who employs new staff) and how services are configured, and is captured in the network agreement. (See Chapter 6 for more on national funding and support arrangements.)

4 Management and back office support arrangements

PCNs require management and back office support. Precisely how those arrangements are configured will in part depend on choices made about the operating model (particularly who employs staff and how much the PCN chooses to keep in-house versus relying on external partners, potentially other providers).

Member practices may require advice on organisational design and legal requirements around set up. In addition to ongoing elements of each of those, moving forwards they will require bookkeeping and financial management, payroll and HR support services, as well as data gathering, storage, sharing and reporting capabilities.

At set up PCNs are required to agree data sharing arrangements between member practices

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(using a national template which it is recommended is reviewed by a qualified professional to ensure it is fully compliant). Given the expectation that PCNs will adopt a population health management approach to inform clinical choices, they will require this on top of those data management capabilities.

5 New service delivery arrangements

The priority delivery arrangements for PCNs to have in place from 1 July 2019 is for extended hours services which transfers responsibility from the practice to the PCN. This is separate from CCG-commissioned extended access services in 2019/20. PCNs will be required to provide additional clinical sessions outside of core contracted hours and based on patient preferences (evidenced by patient engagement). Failure to do so means payment will be withheld.

PCNs will also need to get on with filling new staff roles, moving rapidly towards MDT working in conjunction with non-GP providers, aligning services to provision at place and system-levels, and engaging, liaising and communicating with their local population to introduce the PCN and establish how they will update them on upcoming changes to service delivery.

Guidance available to support set up

This is necessarily a high-level overview. For more detail, see the below core guidance documents. In addition, NHSI/E offers additional content including webinars and the BMA offers a substantial range of guides, blogs, webinars and advisory services. Other guides and support resources available, some free online, some at a cost, from organisations ranging from the National Association of Primary Care to the pharmaceutical services negotiating committee to various legal and advisory firms.

PCN set up supporting guidance

- **Investment and evolution: A five-year framework for GP contract reform to implement the NHS long term plan**
(published 31 January 2019, by NHS England and the BMA)
- **Network contract directed enhanced service guidance**
(published on 29 March 2019, by NHS England)
- **Network contract directed enhanced service contract specification 2019/20**
(published on 29 March 2019, by NHS England)
- **Network contract directed enhanced service mandatory network agreement and network agreement schedules**
(latest version published May 2019 by NHS England)
- **PCNs FAQs**
(third version published July 2018 by NHS England)
- **The primary care network handbook and top ten tips**
(published 2019 by BMA)

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The role of CCGs and LMCs

It is important that providers are aware of the role of CCGs with regard to PCNs, and the complementary role of LMCs.

Ahead of set up, CCGs have been working with LMCs to ensure the whole local population will receive network-level services and ideally every practice is part of a PCN (though technically they don't have to be).

CCGs should be working with practices to ensure all registration requirements are met and that PCN areas are viable and sustainable moving forwards, while minimising disruption to any pre-existing arrangements for joining up primary and community delivery.

CCGs and LMCs are supposed to be providing a link into ICS/STP-level planning to ensure PCN footprints are aligned with the long-term delivery strategy for the larger geography, and should influence how other services can be aligned with PCN footprints in the future.

As CCGs become leaner more strategic organisations with simplified commissioning arrangements for every ICS area, PCNs will be expected to work increasingly closely directly with ICS/STP leadership, representing primary care at system-level integration discussions.

Moving forwards, CCGs will be responsible for monitoring performance and calculating specific payments that go to PCNs.

The BMA Handbook³ also suggests that PCNs draw on their relevant LMCs as an independent mediator in case of any disputes or disagreements within networks.

3 <https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-england/gp-contract-agreement-england/primary-care-networks-pcns/creating-and-running-pcns>

6 Available funding and support

While the long term plan acknowledges that community health services and general practice have insufficient staff and capacity to meet rising patient need and complexity, it goes on to put all the control and funding into the hands of general practice (via PCNs).

On that basis, it will be helpful for providers to understand the range of new funding, contract and support arrangements available to PCNs and general practice, and what they can expect PCNs to bring to the table to support integration moving forwards.

New funding and GP contract arrangements

The local CCG will typically be the commissioner of the network contract DES. That contract will include:

- National service specifications for what all PCNs have to deliver (service requirements will grow as funding grows);
- A national schedule of financial entitlements, including transparency around any sub-contracting arrangements;
- A schedule of supplementary network services agreed locally and funded by additional local resources (both cash and in kind). Where CCGs have local contracts for enhanced services, these will normally be added to the network contract.

Those national financial entitlements flowing down to PCNs include:

- Clinical director post funding (payment per registered patient from July 2019);
- Core PCN funding to support effectiveness (payment per registered patient from July 2019);
- Additional roles reimbursement (claim 70 or 100% reimbursement from when roles are filled);
- Extended hours access funding (a combination of the Extended Hours Access DES now transferred to the network contract DES, and CCG-commissioned arrangements; payment per registered patient from July 2019 with additional funding from 2019/20 as 111 direct booking into practices is introduced nationally). Funding is less than it was before July 2019.

These arrangements are set over a five-year period. By 2023/24,⁴ the network contract is expected to be worth £1.799 billion (or £1.47 million for a typical network covering 50,000 people) in return for phased and full implementation of all relevant NHS long term plan commitments.

This funding is part of a ring-fenced uplift of £4.5bn for primary and community services promised in the long term plan. NHS England/Improvement is very clear that CCGs must not try to use the arrival of any additional funding to disinvest from commitments elsewhere and will proactively pursue any area they think is guilty of this.

4 <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

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Other funding and support available

To implement the long term plan, NHS England/Improvement are clear that ICSs and STPs will have a vital role in supporting the development of PCNs, supported by NHS England/Improvement regional teams.

There is a commitment to provide additional development funding of circa £1m per system on a weighted capitation basis from NSHE/I's allocation for primary care and this will come through ICSs/STPs from July 2019.

Regions will support ICSs/STPs to understand the varied maturity of their PCNs and tailor development support including clinical director leadership development:

- funding will help PCNs prepare to implement future specifications, and to strengthen relationships;
- immature PCNs will receive fast track support;
- NHS England/Improvement will publish a development support prospectus in summer 2019 following a period of extensive engagement with LMCs, PCN clinical directors and providers of community services;
- the clinical director development offer is being co-produced with key stakeholders including the NHS Leadership Academy, The King's Fund, a range of PCN clinical directors, multi-professional clinical advisors and regional directors of primary care and public health.

In addition, other areas have been previously identified for PCN support including:

- primary care fellowship programme and training hubs;
- provision for expected indemnity costs;
- a test bed approach to qualifying new PCN features (see more in Chapter 9);
- existing regional/ICS-devolved schemes that are funded from separate NHS England budgets (e.g. practice nurse development or estates and technology transformation);
- a new investment and impact fund which aims to ensure PCNs benefit from savings achieved across the system and (if agreed with GPC England) will become a national entitlement;
- the new NHS chief people officer will have a focus on succession requirements for future PCN clinical directors as part of national work on NHS leadership.

7 The emerging picture

At point of go live, NHS England/Improvement are looking at roughly 1,260 PCNs coming into being across the country, which is 99.7% coverage.

There has been some inevitable disruption caused by the scale and speed of introduction. While the BMA survey outcomes at the end of 2018 suggested that most practices felt they were already working in a locally-networked way, it is clear that in many areas this has been an opportunity to redraw those existing neighbourhoods/localities/community footprints.

NHS England/Improvement acknowledge this has created a delay in places around progressing wider integration work, but they believe PCNs will prove a more resilient arrangement on the basis that PCN geographies are practice-led and are therefore fully bought into.

NHS England/Improvement also report significant levels of energy coming from primary care behind PCNs, with mass engagement by GPs including all those practices who have previously been hard to reach, and an exciting number of new and younger individuals stepping into clinical director roles (not just GPs but also nurses and pharmacists).

There is some exceptionality, around population sizes, odd geographies and practices who have either struggled to find a PCN to join or simply don't want to. NHS England/Improvement has been working to support PCNs who don't meet minimum sustainable size, and persuade the doubting practices to join.

NHS England/Improvement anticipate that between one quarter and one third of PCNs will be confident that they are already working at scale in a joined-up way, while 15-20% of sites will have little experience of working together locally for a range of reasons.

Provider response

Discussions with over a dozen providers of community services (including acute trusts, mental health trusts, integrated trusts community trusts and large-scale social enterprise community providers) reveals that there is positive welcome of the ambitions for PCNs and recognition that they offer a hugely valuable opportunity to bring primary and community care closer together.

However, to date not everyone's experience has been positive. Where frustration exists it is centred on the observation that the way in PCNs have been introduced (i.e. rooted so significantly in general practice and the GP contract) has created a set of unintended consequences which risks cutting across initial ambitions, including:

- **Delays to progress:** In most places there has been a pause in progressing integration while GPs step back to focus on setting up PCNs. This is manageable provided GPs in PCNs come back to the table post-going live.
- **Volume of new relationships:** The sheer volume of new clinical directors has created a whole cohort of individuals, many of whom are new to this level of working, don't bring the same proven commitment to integration and with whom providers are having to build relationships with from scratch, which can create further delays.

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- **Non-collaborative behaviours:** Providers' experiences of GP behaviours have been mixed. In some areas GPs have stepped back firmly from existing working arrangements and adopted a more contrary position. The impact has been to cause delays and bad feeling on both sides. Providers who are already quite advanced in their integration work (i.e. already established some kind of locality footprints and started working on an MDT basis) are feeling this most keenly. However, in some areas providers were confronted with a large number of independent practices, which made engagement difficult.
- **Setting up competitive recruitment:** Most providers quickly spotted a series of risks around PCN requirements to expand their workforce to populate MDTs. If this is not done in a strategic and collaborative way, there are risks of duplicating existing roles and competing to recruit from a limited local talent pool. More than one provider reports that GPs have responded to this challenge by noting that as they're not bound by Agenda for Change terms and conditions, they'll simply pay those individuals more to bring them on board. There is evidence that providers are trying to be creative in how they work with PCNs to fill these posts (including offering to second in existing staff in Year One), but given longer-term national workforce challenges this is an understandable source of concern. For instance, though paramedics are not due to be brought on until 2021, the Association of Ambulance Chief Executives believes that the PCN framework as it currently stands could lead to a significant loss of experienced and essential paramedics. This is likely to exacerbate gaps within an already overstretched ambulance workforce and potentially threatens the stability of urgent and emergency care systems across England.
- **Complexity based on geography:** In a number of places, in spite of requirements in core guidance about getting set up on geographies that make sense to other local providers, PCNs have been created which cut across existing localities and established areas of neighbourhood-level working. In certain places practices within the same PCN are physically distant from one another, with practices from different PCNs in between. In those areas, community service providers are struggling to make even their community nursing arrangements viable with staff having to work into multiple MDTs in different PCNs.
- **Complexity based on level of service delivery:** Further complexity is being raised by some initial misalignment between GPs and community providers on the question of what is the right level at which different services should be delivered (i.e. neighbourhood vs place vs system). Further to that, in some places there are debates around whether the PCNs are just one player within a neighbourhood, or whether PCNs are the new neighbourhoods and everything should go through them. In every instance, the answers (or lack of them) has consequences for what services and staff sit where.
- **Commerciality and suspicion:** In some areas it was noted that GPs and GP Federations were responding to the introduction of PCNs as a commercial opportunity and putting themselves forward in an aggressively competitive fashion that was making collaboration more difficult. One provider already has PCNs on their risk register as a threat to their contracts. It is acknowledged by all that providers themselves can be equally guilty of overtly commercial behaviours, though those we spoke to felt they had adopted a wholly collaborative position.
- **Reinforces siloes of variable quality:** A couple of providers flagged a risk that on the basis that good practices often gravitate towards good, that means struggling practices will end up with others who are similarly struggling, and the impact will be to cement pockets of poor performers into new siloes that will be hard to bring up to par.

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The next nine months

After achieving the goal of becoming established by 1 July 2019, the real work now begins for PCNs. Equally, this first nine-month window through to 1 April 2020 is an absolutely critical time for providers.

Local providers need to be round the table with PCNs, working together to ensure they are robustly set up and preparing collaboratively for the upcoming national specifications which will require joined-up delivery.

In this chapter, we look at the emerging picture from the run in to 1 July, important early priorities for PCNs and providers, and what new funding and support will be available.

Collaboration is *the* priority

NHS England/Improvement has stated that PCNs have variable ability to engage with every potential partner depending on the strength of pre-existing relationships and having been understandably distracted by meeting the requirements for set up.

However, it is now critical that PCNs focus on their function as a network and building strong working relationships.

The anticipation is that where they don't already exist critical relationships will build over the remainder of 2019/20, and that when network agreements are first updated for April 2020 they will reflect those wider working arrangements required to deliver the national service specifications.

Commitments from NHS England and NHS Improvement

Over the next nine months, NHS England/Improvement will be focusing on a number of critical approaches, including:

- A commitment to communicate upcoming PCN requirements to primary and community providers in tandem, providing guidance to both to ensure they are supported to work in a complementary way;
- Communicating early to PCN and community leaders so they are clear what they need to do to get ready to respond to the funding coming out, what relationships and practical arrangements need to be in place;
- Taking a 'test bed' approach, identifying PCNs who can test - with rapid cycle evaluation - features which need testing in principle or in implementation and could in future be part of contractual arrangements (e.g. upcoming service specs, new workforce roles, new and additional services or other innovations). Notably this will not necessarily be PCNs who are more developed, but more likely those that are typical.

8

Early tasks for PCNs

PCNs will be expected to move quickly to meet initial service delivery commitments (particularly extended hours access), setting up for MDT working in partnership with other local providers and contributing to reform of urgent care responsiveness in communities.

PCNs will begin recruitment of a clinical pharmacist and a social prescriber, which may well prompt dialogue with local non-GP providers who already employ these professionals. They may also focus on upskilling existing staff to be able to take on more responsibilities.

In anticipation of growing responsibilities and workforce, and the need to physically deliver more support in primary care settings, PCNs will need to stress-test the resilience of their set up arrangements and potentially consider their physical infrastructure and access to existing community locations. In both cases, other local providers may be well-placed to offer cost-effective solutions.

PCNs will need to get themselves ready for the first of the national specifications heading their way for April 2020, focused on providing support into care homes and an MDT approach informed by population health management. NHS England/Improvement are clear that even these initial obligations cannot be met unless PCNs are working in trusted partnerships with other local providers.

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April 2020 onwards

As capacity within PCNs increases over time, so minimum national activity levels will increase accordingly and providers should be clear on the speed at which PCNs are expected to move.

National service specifications

In return for the increased investment, PCNs are contracted to deliver seven new national service specifications which cover 41 requirements that implement many of the primary and community care commitments in the long term plan.

The specifications will be designed by NHS England/Improvement through 2019/20, agreed with the BMA and included in annual updates to the network contract DES.

The seven specifications are from April 2020:

- 1 Anticipatory care for high need patients with complex long-term conditions.
- 2 Enhanced health support in care homes, scaling up lessons from the vanguards.
- 3 Structured medications review and optimisation.
- 4 Personalised care, i.e. implementing the NHS Comprehensive Model.
- 5 Supporting early cancer diagnosis.

And from April 2021:

- 6 Cardiovascular disease prevention and diagnosis.
- 7 Tackling neighbourhood inequalities.

By way of illustration of the criticality of strong PCN-local provider relationships, the NHS England/BMA contract guidance is explicit that the anticipatory care specification requirements need to be delivered jointly by fully integrated teams and are critical to moving towards breaking down historical barriers between primary and community services.

This will require input not just from general practice and community service providers, but also social care and local hospitals, and will only be possible through “excellent working relationships and close collaboration.”⁵

5 <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

9

Towards maturity

PCNs will be expected to be able to demonstrate progress on key metrics from April 2020, supported by the introduction of a new national network dashboard.

NHS England/Improvement have produced an early version of a maturity matrix designed to support local systems to assess their progress, and step 1 makes some big asks, including:

- PCNs are engaged in joint-planning around delivery of out of hospital services
- PCNs are contributing to their ICS plan and representing primary care in strategic decision-making at a system-level
- MDT working is in place and population health segmentation of patients is happening.

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Table 1
NHS England/Improvement maturity matrix

Foundation	Step 1	Step 2	Step 3
<p>Plan Plans in place articulating a clear vision for primary care and PCNs and steps to getting there, including actions at network, place and system level. 100% coverage of PCNs.</p> <p>Engagement GPs, local primary care leaders, patients' representatives, and other stakeholders believe in the vision and the plan to get there.</p> <p>Time Primary care, in particular general practice, has the headroom to make change.</p> <p>Transformation resource There are people available with the right skills to make changed happen. PCN DES requirements (including clinical director and network agreements) fulfilled by all PCNs across system.</p>	<p>PCNs have agreed shared development plans. Joint planning is underway to improve integration with broader 'out of hospital' services as networks mature. There are developing arrangements for PCNs to collaborate for services delivered optimally above the 50K footprint.</p> <p>Primary care providers have a seat at the table for system strategic decision-making.</p> <p>Analysis on variation in outcomes and resource use between practices and PCNs is readily available and acted upon.</p> <p>Basic population segmentation is in place, with understanding of needs of key groups, their needs and their resource use.</p> <p>Integrated teams, which may include social care, are working in parts of the system. Plans are in place to develop MDT ways of working, including integrated rapid response community teams and the delivery of personalised care.</p> <p>Common components of end state models of care defined for all population groups, with clear gap analysis and workforce plan.</p> <p>Steps taken to ensure operational efficiency of primary care delivery and support practices experiencing challenges in delivery of core services.</p> <p>PCNs are engaging directly with their population and are beginning to make use of wider community assets. PCNs are engaging directly with their population and are beginning to make use of wider community assets. PCNs have undertaken an assessment of the available community assets that can support improvements in population health and great integration of care.</p>	<p>Primary care plays an active role in system strategic and operational decision-making, with mechanisms in place to ensure effective representation of all PCNs at place and system level. PCN Clinical Directors work with the ICS leadership to share learning and work collaboratively to support other PCNs.</p> <p>All primary care clinicians can access information to guide decision making, including risk stratification to identify patients for proactive interventions, IT-enabled access to shared protocols, and real-time information on patient interactions with the system.</p> <p>Early elements of new models of care defined at step 1 now in place for most population segments, with integrated teams throughout system, including social care, mental health, the voluntary sector and ready access to secondary care expertise. Routine peer review takes place.</p> <p>Networks are beginning to implement the comprehensive model for personalised care.</p> <p>Functioning interoperability within networks, including read/write access to records, sharing of some staff and estate. PCNs and other providers have in place supportive HR arrangements that enable multi-agency MDTs to work effectively.</p> <p>Networks have sight of resource use and impact on system performance and can pilot new incentive schemes.</p> <p>PCSNs are routinely making use of wider community assets in meeting their population's needs.</p>	<p>Primary care providers are full decision-making member of the ICS leadership, working in tandem with other partners to allocate resources and deliver care.</p> <p>Systematic population health analysis allowing PCNs to understand in depth their populations' needs and design interventions to meet them, acting as early as possible to keep people well. PCNs' population health model fully functioning for all patient cohorts.</p> <p>Fully integrated teams throughout the system, comprising of the appropriate clinical and non-clinical skill mix. MDT working is high functioning and supported by technology. The MDT holds a single view of the patient. Care plans and co-ordination in place for all high risk patients. The comprehensive model for personalised care is fully implemented.</p> <p>Fully interoperable IT, workforce and estates across the networks, with sharing between networks as needed.</p> <p>PCNs take collective responsibility for available funding. Data is used in clinical interactions to make best use of resources.</p> <p>The PCN has fully incorporated integrated working with local Voluntary, Community and Social Enterprise organisations as part of the wider network, that supports meeting comprehensively the health, care and wellbeing needs of the PCN's population.</p>

This matrix is being evolved by NHS England/Improvement and an updated version will be published later this year.

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What role can community providers play?

Providers of community services are well advised to think of engaging with PCNs on two different fronts:

- 1 As new strategic partners in the pursuit of system integration.
- 2 As suppliers of practical hands on support.

Strategic partners

For PCNs to achieve their full potential it is vital that providers of community services are able to work effectively with them in trusted relationships.

Some providers of community services are feeling a little bruised off the back of the introduction of PCNs. While there had clearly been quite detailed and involved consultation with primary care stakeholders, next to no consultation had been done with the other half of the primary-community divide that the NHS long term plan aims to bridge.

But where there are negative consequences from PCNs it is providers who are feeling the impact (see Chapter 7 for more on that experience).

It is true that the opportunity PCNs have provided for GPs to effectively impose their own preferred neighbourhood footprints around which community providers are mandated to work has caused friction in some areas, particularly where providers feel it has reversed (at least temporarily) progress made toward integrated working.

It is also helpful to recognise that the injection of funding into primary and community care via general practice has rebalanced local relationships, forcing established relationships to be re-evaluated and bringing new players to the table.

Having recognised these challenges where they exist, it is critical that providers and PCNs find a way to work collaboratively to ensure that the system integration agenda continues to progress. (See more below on how best to make that happen based on provider experiences to date.)

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Suppliers of practical support

There is an indication that in a number of cases PCN set up arrangements will only be rudimentary, and even where there are mature practices in the mix many will nonetheless have gaps in what they need to operate effectively. This means there is a strong rationale for non-GP providers to help ensure those areas have the support they need to succeed.

Given this mixed picture of capacity, capability and resilience, PCNs are able to draw support from a range of local partners from within the health system, local authorities or third sector organisations.

As identified in Chapter 4, there are five areas where providers should think about the kind of hands on support they might be able to offer PCNs:

- 1** Governance and decision-making arrangements:
 - designing joined-up decision-making models
 - robust clinical governance arrangements at scale
 - potentially sitting on PCN boards in the future.
- 2** New roles and employment arrangements:
 - hosting/carrying employment liabilities
 - subsidising specific positions
 - meeting professional support and development requirements, including for leaders
 - meeting occupational health requirements
 - joint approach to workforce planning and local recruitment.
- 3** New funding arrangements:
 - holding the bank account
 - financial account management.
- 4** Management and back office support arrangements:
 - ongoing organisational design support (including access to business management processes and tools, risk management support, regulatory compliance)
 - access to market intelligence and population health management analytics and tools
 - support around data sharing governance and review
 - transactional HR/payroll support
 - legal and tax advice
 - ICT support
 - estates and facilities management.
- 5** New service delivery arrangements (beyond that which is required within the national specifications):
 - workforce planning (e.g. Birmingham Community Healthcare NHS Foundation Trust has done some great data modelling to show the challenges of ensuring a viable ratio of nurses to individual practices based on the geographical spread of patients)
 - support around patient and public engagement
 - support around pharmacy and social prescribing where providers already delivery this
 - support around sharing premises (e.g. to help deliver requirements on extended hours).

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Lessons from provider experience on how to best engage with PCNs

Lessons from provider experiences to date suggest that collaboration with PCNs is strongest where there are well-established pre-existing relationships and the practices within the PCNs are already thinking and operating in an integrated way with local partners.

However, this is not always the case. If (for whatever reason) providers of community services are faced with difficult challenges in engaging with PCNs, the following observations drawn from conversations with providers might be helpful:

- **Be patient and don't panic (yet).** Given everything that has been asked of them to get established, it is unsurprising that GPs have taken their eyes temporarily off integration. Give them a chance to come back to the table.
- **Don't stop collaborating.** Where providers feel that GPs or PCNs are not collaborating, try to protect relationships, don't let bridges get burned (recognising this is not entirely down to you). Even if it doesn't feel like it today, there are multiple reasons why PCNs will need to collaborate in the future:
 - Guidance from NHS England/Improvement on the need for collaboration will be explicit and will only continue to be more so: engage as early as possible in preparation for the national specifications which (when they appear in April 2020) will require PCNs to deliver outcomes that they cannot deliver on their own – they will require the support and partnership of community providers.
 - Come April 2020, the network contract DES will require governance arrangements that take account of community providers, and those arrangements will need to be reflected in a revised network agreement.
 - The initial NHS England/Improvement maturity Index is clear that effective joint working is an early step 1 PCN characteristic.
 - Lessons from the more mature primary care home sites are that the most successful are those who engage well with all other local providers.
 - It will become quickly apparent that making community services operate effectively at scale, across levels of neighbourhood, place and system, is a significant and complex task.
- **Focus on relationship-building.** Easy to say, very hard to do when the relationships are fractured or don't exist. The following are taken directly from providers who have had good and bad experiences to date:
 - **Transparency of motives:** Get clear up front what your motives are (e.g. your commitment to shared integration goals and to support PCNs to succeed for the good of the whole system), and what your motives are **not** (e.g. to empire-build, take over primary care, seize the new funding for yourselves as soon as it arrives, capitalise on PCNs as a purely commercial opportunity).
 - **Get the tone right:** In line with your motives (see above) avoid being overly controlling, commercially aggressive, making assumptions about the motives of other parties.
 - **Be proactive but not pushy:** Strike the right balance of reaching out, find neutral forums/ set up events in which to hold constructive dialogue.

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- **Make culture a strategic priority:** Take the focus off contract requirements and structures, and build in a recognition of the importance of effective working relationships, collaborative behaviours and system thinking at all levels (not just leaders).
- **Getting going:** Professionals often thrive in collaborative working environments and the sooner you can get your staff into MDTs with people who haven't worked that way before, the sooner you will challenge any sceptics – look for early opportunities to build good faith and demonstrate your motives are genuine.
- **Present benefits of joint-working:** Put yourself into the shoes of PCNs, identify what the benefit will be from joint-working, with evidence if you have it.
- **Design a practical support offer focused on meeting PCN requirements.** It sounds obvious, but really work to tailor what you can do to help PCNs meet the requirements they face early on. Try not to come across as overly commercial or formal in 'selling' it to them. Find ways to make your offer known, and then let them come to you.
- **Focus on outcomes not processes.** Keep your sights on the potential to deliver improvement for patients through joint working between health and care rather than local power struggles – focus on the next nine months rather than the last six.

Provider asks of NHS England/Improvement

NHS England/Improvement have been very clear that they will continue to do everything needed to support PCNs to succeed and remove the barriers between primary and community services. Below are a handful of the requests coming from providers we spoke to:

- be as directive as possible about the need for GPs and PCNs to collaborate with community providers in the spirit of effective integration
- consider what incentives can be built into the roll out of national specifications that ensure collaborative PCN behaviours
- ensure regional teams work closely with areas where integration progress has been arrested and relationships are suffering, potentially causing avoidable further delay
- ensure (as has been suggested) that communications and engagement moving forwards are done in parallel with both primary and community providers
- offer a national steer on the importance of collaborative workforce planning and ensure a level playing field for pay, terms and conditions.

The Community Network, including NHS Providers and NHS Confederation, will continue to push for these asks with NHS England/Improvement. If you have more suggestions, questions or challenges, please reach out to the Community Network.

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Case studies including support offers

The three case studies below detail the experience of three providers of community services who are particularly advanced in considering their support offer to PCNs. Each case study looks at both their strategic partner response, and their practical support response including a summary of their detailed offer.

CASE STUDY

Sussex Community NHS Foundation Trust (SCFT)

Stand-alone community trust

Strategic response to PCNs

SCFT have been operating to the principles of MDT working over the last four years, so strategically PCNs are a good fit. Their principal challenges are around implementation of new neighbourhood footprints and implications for workforce.

SCFT's original *Communities of practice* strategy aimed at bridging the gap between staff based in general practice and in community settings to create MDTs around clusters of GPs – in other words, an early iteration of a PCN. It was supported by GPs and CCGs and has been rolled into their contract for the last two years. Even with a little variation on the patch (one CCG commissioned the model as local community networks), primary and community staff were used to working in a joined-up way.

PCNs should be an easy next step but have created a (hopefully) temporary logistical headache because they have not formed up in a way that maps against existing GP clusters. In some instances, PCNs are not even geographically coterminous. This means multiple MDTs are faced with working into single PCNs, seemingly defeating the purpose of the approach.

SCFT are keen to work closely with PCNs to mitigate the disruptive impact of this on their teams. There is recognition that some reworking of geographies will be positive, but also that certain advantages of the previous arrangements risk being lost.

For instance, Sussex GP Federations are at varying levels of maturity and although they are collaborating, there is still an element of local competition. The implications of PCNs for a GP provider operating at that scale is unclear, and their previous role providing a strong voice for primary care and leading discussions with a strong spirit of locality may well be dissipated.

SCFT are also needing to agree a consensus view with GPs on how PCNs can align themselves with existing services operating at different levels of geography (i.e. whilst adult community nursing would be a day-to-day part of MDT working, more specialist services like dental services and medicines optimisation will need to work across place/multiple PCNs).

SCFT have as yet unresolved concerns around whether local workforce supply will be able to meet the explicit requirements around some specialist roles, particularly if PCNs choose to recruit directly, and would welcome a stronger steer from NHS England/Improvement on how this could be addressed.

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Practical support offer to PCNs

Based on their depth of experience in MDT working and a strong capability in strategic development and partnership supported by dedicated teams, SCFT have been able to lay out a clear support offer that describes a vision for how staff can work together, and a set of specific practical areas of support to help PCNs establish themselves over the next nine months.

Their offer focuses on infrastructure support services and doesn't include back office resources, based on a clear steer taken from early conversations with GPs. Those initial discussions allowed for a kind of 'soft-testing' of what PCNs might welcome and were positive in tone.

Dialogue focused on how to join together skills and competencies, particularly around nursing roles (community nurses, district nurses, advanced nurse practitioners), in a way that would reduce hand-off's and fragmentation in patient pathways.

SCFT have packaged together their offer and feel that they've ended up in a 'pseudo-competitive space' where their main competitors are local GP Federations.

In terms of PCN decision-making models, by early June 2019 SCFT had not been invited to play any formal roles in governance arrangements nor had their role been reflected in any network agreements.

The SCFT offer

is captured in a short, fully-formatted Word document that sets out:

A vision for how SCFT will arrange and align existing services to support PCNs, setting clear expectations on both sides and maximising coordination of care. That vision includes:

A clear account of how specific commissioned service lines will be best suited to operate at different geographical levels, including:

- **Level 1 – aligned services:** arranged to reflect new PCN structures and support MDT working.
- **Level 2 – coordinated services:** operating across multiple PCNs where service needs larger than 50,000 population size to enable delivery, maintain clinical skills and workforce resilience.
- **Level 3 – specialist services:** operating across much larger geographies due to specialist nature of roles, specified clinical pathway or variable demand.

An outline operating model for how Level 1 services could work effectively under four headings:

- **Workforce:** details which types of staff, how they will be employed, supervised and managed.
- **Culture:** describes what type of culture SCFT want be part of and how this supports patients.
- **Systems and processes:** sets out which SCFT believe are core to working effectively together.
- **What SCFT need from practices:** identifies the reciprocal support required to deliver collectively.

An offer to utilise SCFT support services and expertise to underpin PCN clinical services, including:

- **Host employment for specific additional roles:** SCFT experience shows that even while working in MDTs, professionals are most effectively supported in their professional groups; specific areas of support are listed including supervision, indemnification, revalidation (where needed), and access to the NHS Pension scheme. SCFT scale ensures workforce resilience and continuity of services, particularly where individual practices only need fractions of full-time roles;
- **Population health information:** offer of analytical services to support population profiling and segmentation, can support PCN staff to use risk stratification tools;
- **Occupational health services:** SCFT have a fully accredited award-winning support offer;
- **Training and education support:** wide range of statutory, mandatory and additional course, access to booking platform integrated with the electronic staff record and bespoke training as needed.

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CASE STUDY

Midlands Partnership NHS Foundation Trust (MPFT)

Integrated mental health and community trust

Strategic response to PCNs

MPFT has existed as a merged entity for roughly a year, bringing together physical care and mental health services from specialist trusts. They spent 12 months building an enhanced primary and community care approach based on an expectation of creating multispeciality community providers (MCPs), led by GPs and focused on keeping people out of hospital.

MPFT had identified around 23 localities of between 30,000 to 50,000 populations and were identifying how to address variable levels of practice sustainability, and a mixed picture of service delivery with gaps, areas of duplication and unwarranted variation.

The historic relationship between the community provider and GPs had been competitive and marked by a lack of trust. MPFT used the merger as a mechanism to introduce a vision for truly integrated care.

Integrated care teams were established by MPFT that aligned to the localities and the developing MCPs. This ensured that each MCP would be clear on their allocated workforce and locality teams that would support their population.

It was highly welcomed therefore when PCNs were introduced as they matched this approach.

MPFT have been working to allocate their community resources into 26 PCNs, including a clear allocation of staff to support clinical delivery. Aim is to complete that allocation against all service areas, including long-term conditions and urgent care, to support patients to remain in community settings without ended up in A&E.

The particular benefit MPFT have seen is that where previously organisations had put up walls, these new arrangements promote a constructive dialogue focused on patient welfare at a managerial level that is equivalent to the kind of clinical exchange that happens in MDTs. Local negotiations around resources can take place without needing to make changes to overarching national contracts.

MPFT are conscious that funding will become more complicated as PCNs move to capitated arrangements in year two, and are keen to see how ICS-model working will deploy through PCNs and trust providers over the next two to three years.

Practical support offer to PCNs

MPFT have tried to respond to areas within the network contract DES where they believe PCNs might welcome specific support and are already in discussion with a number of PCNs who are interested in what they can offer.

They have created a menu of support elements that practices and PCNs can draw down as and when they see the need. That offer includes acting as a host employer, plugging additional roles into professional networks and existing CPD offers and offering access to back office services.

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In addition, where individual practices are unviable MPFT are prepared to temporarily drop in support to keep them going, and ultimately consider potentially employing GPs and sub-contracting GMS arrangements. However, that would be by exception as MPFT are keen not to dilute their own offer and are clear they have no wish to take over primary care provision.

In terms of population health analytics, MPFT are also providing population health analytical support for all 26 PCNs to establish as much clarity as possible on the challenges the area will face over the next two to five years and what they collectively need to respond to that.

The MPFT offer

is captured in a branded powerpoint presentation that sets out:

A clear intent to work in partnership with primary care colleagues to enable integration of primary and community care through PCNs. That commitment includes collaborating to put in place Integrated care teams, to shape optimal services and workforce, to add value to PCNs through providing additional clinical services based on demand, and to offer a wide range of corporate services to help save time and money.

In the first instance, that has involved supporting PCNs to get configured and established, supported by workforce modelling to align teams at alliance, hub and PCN levels in North, South and East Staffordshire.

MPFT have then tailored their comprehensive range of support services to help PCNs meet the requirements of the network contract DES, including:

- Financial account management: Hold core PCN funding that GPs can invoice to or draw down from;
- Practice staff recruitment: Manage recruitment of key practice staff as and when required, including interview process;
- PCN employment: Host and employ key roles allocated to the PCN, this will include day to day management support;
- Strategic support: To develop and implement strategic plans;
- Quality improvement: Access to Lean methodology and modernisation processes, incident and risk management support, regulatory compliance and quality assurance;
- Workforce development: Access to HR services, workforce planning, leadership development, statutory and mandatory training and occupational health services;
- Market intelligence: Analytics to run key business insights through a market intelligence tool, including demographic analysis and prevalence, and health profiling per PCN;
- Patient engagement: Advice and guidance around patient/service user engagement and development of an engagement plan;
- Pharmacy: Support strategic delivery of practice-based pharmacy, including training and peer support, medicine review for long-term conditions and medicines optimisation.

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- Partnership development: Lead development of a shared plan for social prescribing.
- Extended hours: Offer premises for additional clinical sessions, and support in promotion and publication of the days and times of appointments.
- Contractual support: Development of outcome frameworks, financial and contractual modelling, legal advice and support, and help to run procurements.
- ICT development: Development and roll out of ICTs and hubs, a workforce plan, help to meet IM&T and estate requirements.
- Mobilisation and operational delivery: Support implementation and mobilisation, managing the administrative aspects of general practice, and IM&T system installation and management.

This PCN-specific menu builds on MPFT's well-established offer to promote clinical and financial sustainability at the level of individual practices, who can choose from even richer menus of clinical and non-clinical services from which they can tailor a bespoke support offer, or else chose from Gold, Silver and Bronze packages.

MPFT set out a clear benefits case to GPs for drawing on their support, including:

- Corporate services that help drive efficiency through economies of scale;
- Consolidating back office functions to protect clinician capacity;
- Reduced administration burden;
- Opportunity for investment into general practice with the ability to use a greater infrastructure;
- Better redistribution of resources into primary and community care.

To bring this to life and take it off the page, MPFT have reached out to host an event with clinical directors and NHS England to explore successful working together.

11

CASE STUDY

Northumbria Healthcare NHS Foundation Trust (NHCT)

Acute trust with community and adult social care

Strategic response to PCNs

NHCT re-energised its integration and community-facing work nine months ago, building a locality-orientated programme, and reaching out to other providers within the local system to work in a more integrated way at a neighbourhood level. Unlike the turf wars and fallings out over money of the past, this latest approach has been getting good traction.

The arrival of PCNs has definitely distracted the primary care community a little, which is felt to be understandable given the contractual consequences PCNs hold for them. However, NHCT has encouraged the view that PCNs are a natural partner of its own neighbourhood approach and have sought to support PCNs to look beyond a narrow focus on contractual commitments.

The NHCT board has a publicly stated strategic priority to support primary care and implement place-based, integrated care delivered by cross-system flexible teams – they are keen to ensure that support offered to PCNs to get established over upcoming months goes well beyond what might be expected. NHCT believe robust and resilient PCNs will be key to resource and re-design decisions that help the whole system and maximise opportunities for system working.

NHCT acknowledge that in the past the trust view has been less well connected than it should be, and are equally clear that acute institutions should not be trying to dominate primary provision.

However, they are also concerned to ensure that with the arrival of PCNs, primary and community care don't build a wall between themselves and acute colleagues.

The NHCT priority is to avoid reinforcing old prejudices and support everyone to be at the table with a voice in an ongoing dialogue to advance integration – focused around citizens, embedded in localities and neighbourhoods. NHCT are keen to ensure that this latest approach is nurtured collectively and that there is sufficient focus on behaviours over structures; in other words recognising and fully supporting the organisational development (OD) needs of PCNs.

Practical support offer to PCNs

NHCT have initially broadcast their intention to offer whatever support is needed in the first instance, inviting PCNs to hold informal dialogue with them about what that might be.

On the Northumberland side of NHCT's patch that offer went out originally through their system-level integration arrangements – while in North Tyneside where the system mechanics are perhaps less well developed, they have gone directly to GPs in nascent PCN areas.

NHCT's preferred approach has been to work through those with good existing relationships wherever possible, rather than an overly formal and corporate approach – partly because their offer is intended to be responsive to what different areas are looking for, but also to underline that there is no corporate conspiracy to park their tanks on anyone else's lawn.

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NHCT's starting point has been that they have a strong track record in OD and supporting infrastructure, have staff they would be prepared to devolve into PCNs, and are willing to subsidise some roles in year one. They are phlegmatic that some PCNs may be suspicious of these offers of support and suspect ulterior motives, but also note that many others are receiving the offer well.

Initial dialogue between Northumberland PCNs and their CCG has highlighted a number of priority areas where PCNs are looking for support in year one. NHCT have identified an initial response applicable to all patch PCNs, but beyond this is committed within reason to offer whatever they can to support the broader aim.

The NHCT offer

to date has deliberately been shared informally in emails or verbally and includes:

Leadership development: NHCT are offering to extend the trust leadership development portfolio to primary care (including non-GPs), and additionally develop a bespoke offer to meet PCN needs. A number of their current leadership programmes are already available to GPs, managers or any potential PCN leaders, including strategic leadership and clinical leader programmes. NHCT would recommend that wherever possible PCN clinical directors take on development programmes alongside their new aligned community clinical nurse leaders to help build relationships, trust and understanding.

Organisational development: The system approach includes support for wider network team development beyond just PCN clinical directors, supporting establishment of governance arrangements for PCNs, prioritising clinical development areas and linking with system partners. Specifics of the NHCT offer include:

- seconding middle-to-senior managers into PCNs where there is a common desire and appropriate match;
- potential placement of graduate management trainees into PCNs, not least to ensure that future senior managers better understand primary care and the PCN approach;
- cross-system quality improvement work bringing acute, primary, community and social care, colleagues together to re-design use of resources across clinical pathways;
- regular shadowing opportunities for those in clinical and non-clinical roles across different sites and services promoting stronger understanding of each other's roles, responsibilities and challenges.

Legal and tax advice: Offering fast track access to legal advice for emerging PCNs drawing on the Trust's well-established relationships with external legal advisors, as well as access to in-house expertise. NHCT has recently provided detailed briefing on VAT issues for Northumberland PCNs with advice on managing risk through use of cost sharing groups.

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Workforce and employment support: NHCT are keen to use their well-recognised physio and pharmacy departments to support rapid network team development, creating a sustainable workforce pipeline to supply clinical pharmacists and first contact physios to the PCNs. Specifically, NHFT is offering to use a sub-contracting model to provide:

- senior clinical pharmacists to work in PCNs, covering the 30% of costs in 2019/20 for six positions that won't be covered by the 70% reimbursement available from central funding;
- first contact physiotherapists to work in PCNs covering 100% of the costs of four positions for the remainder of 2019/20.

NHCT believe the model offers the following benefits:

- largely removes employment and operational risks for PCNs;
- manages risks encountered around leave including lengthy sickness and maternity absences;
- builds in supervision and support and prevents professional isolation
- meets CPD expectations and requirements;
- supports portfolio careers for staff who wish to rotate through community and acute settings;
- additional learning from staff rotation improves system understanding and trust and drives stronger MDT working.

While there may be a perceived downside of not fully 'owning' staff, NHCT believe that this approach is well-placed to support the creation of cohesive, stable multi-disciplinary network teams, still with full operational control and committed team working at PCN level.

In addition to supplying additional capacity to relieve pressure on GPs, NHCT are clear about the need to respond to workforce challenges at a system level to prevent destabilisation from competitive recruitment across the same geography. This should be broader than just the additional roles specified in the PCN guidance and become for foundation of joint working, whether PCNs choose to employ staff directly or use NHCT or another provider as hosts.

While this element has been led by the CCGs, NHCT will play their part in ensuring social prescribers are linked into ongoing programmes bringing together partners across the system to maximise PCN resources and potential. Associated trust sponsored work is looking at how third sector partners can be better integrated as both advocates and service providers into neighbourhood work, with increased understanding of NHS staff as to the added value they bring.

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Communications and engagement: NHCT can support PCNs to plug into existing resource and approaches to communications and public engagement across the system. Specific areas of support identified by the trust include:

- support for a press and social media campaign to position the benefits of PCNs, including case studies focused on the benefits to the public;
- media handling support including social media;
- website presence if required; potential shared use of on-line platforms;
- networking the Patient Participation Groups, and supporting consistency around role of and responsiveness to them;
- ensuring PCNs are firmly part of a region-wide engagement planned for later in the year to allow their greater visibility and opportunity to talk with a range of community representatives;
- support for effective communications within PCNs, as well as between PCNs and other system providers, as part of continuous communication flows; also with wider stakeholders, including health and well-being boards/overview and scrutiny committees.

Data analytics and population health: NHCT have significant dedicated public health expertise and capacity, including recent investment in population health analytics. The trust will work closely alongside the CCG and LA public health colleagues to support PCNs to understand the data available to them, to access it from a range of sources and triangulate it to provide population insights.



Acknowledgements

It is important to thank all of the senior individuals at the following organisations who took the time to share their insights and experiences to inform the content of this briefing, including:

NHS England/Improvement
National Association of Primary Care
Association of Ambulance Chief Executives
Sussex Community NHS Foundation Trust
Midlands Partnership NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
Bridgewater Community Healthcare NHS Trust
Whittington Health NHS Trust
Tameside and Glossop Integrated Care NHS Foundation Trust
Birmingham Community Healthcare NHS Foundation Trust
Central and North West London NHS Foundation Trust
Care Plus Group CIC
Medway Community Healthcare CIC
City Health Care Partnership CIC
Spectrum Community Healthcare CIC

Suggested citation

NHS Providers/NHS Confederation (July 2019),
Primary care networks: a quiet revolution.





Community NETWORK

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