NHS
South West
Clinical Senate

Clinical Senate Council Meeting

Thursday 23rd May 2019
South West Clinical Senate Council: Primary Care Networks

Question

What is the role of Primary Care Networks in the development of high-quality health and social care services, care pathways and improved clinical outcomes in the South West?

Overview

This topic was proposed by South West CCGs and NHSE following the January 2019 Clinical Senate Recommendations on the role of community pharmacy in the context of primary care delivery, and which had a significant focus on the opportunities that Primary Care Networks bring for the integration of community and primary care.

Given the national timeline for Primary Care Network coverage arrangements across regions to be confirmed imminently with the GP contract to go live on 1st July, these recommendations are particularly timely. They seek to provide guidance on how best to support primary care networks in the South West as they develop to ensure the best clinical outcomes for patients.

In developing these recommendations, the Clinical Senate brought together CCG clinical leads, CCG and NHSE Primary Care leads, Health Education England and the National Association of Primary Care as well as regional GP leads experienced in the establishment of primary care networks and primary care homes, to present evidence and consider the role of Primary Care Networks as part of integrated community care going forward.

Evidence

Primary Care Networks (PCNs) are being set up as an integral part of the 2019 GP contract to support ongoing implementation of the GP 5 Year Forward View. Whilst there is one off funding to support set-up, PCNs are acknowledged to be wider than GP practices and health services in their establishment, requiring meaningful community engagement and integration. The Clinical Senate heard how the aspiration for PCNs is to help create primary care resilience at scale, in part to address the ongoing crisis in the GP workforce and with the intention to create an architecture for integration. Successful PCNs would be expected to initiate workforce innovations, efficiencies such as merged back office functions, improved Clinical Governance, increased collaboration and the opportunity to pilot integration projects.

Although not yet confirmed the predicted number of PCNs across the South West is currently 96. Whilst PCNs offer a useful framework to initiate service delivery around population health it was noted that there will be some issues to bear in mind and address as PCNs develop. Some of these issues were highlighted as follows;

- There are different starting positions across the South West for different PCNs.
- As networks, PCNs will be numerous and relatively small in size. Thought therefore needs to be given as to how to effectively link in with and communicate with them, as well as what they can reasonably be expected to deliver in comparison to now.
- Whilst PCNs are not commissioner driven and should be locally led there are some contractual and time limited obligations to adhere to with regional support required for some consistency.
- Digital intra-operability or the lack of it could limit the development of services.
- The interface with other providers, particularly Community Service Providers, will be key.
- The PCN Workforce will be drawn from the existing workforce but at the same time is being encouraged to become tailored to population needs.

The Clinical Senate heard that while the current focus for PCNs is on practice coverage, they will not and should not be GP networks but multi-disciplinary primary care networks that are made up of and link with pharmacists, AHPs, nurses, community providers and secondary care amongst others.

Clinical Directors are currently being appointed and will be the key point of contact for PCNs but will only be contracted one day a week. The intention of delivering primary care at scale to a population of 30-50 000 people means that every patient will be covered by a PCN. Whilst the front door won't visibly change for patients, PCNs should provide a framework for that patient to access a greater range of services and a wider workforce beyond that traditionally offered by their GP Practice.

Primary Care Homes have in some areas been the predecessor to PCNs. Whilst these have been very successful and support the 30-50k population concept, the learning and feedback from clinical leaders involved in these has clearly been that success comes from investment in relationship building and trust across practices and with community teams. The population coverage benefits from a scaling up of services at a critical level but without losing the close working relationships required in the workforce, as well as the knowledge of the patient population and benefits of risk stratification and personalisation of care that can still be offered.

The National Association of Primary Care referenced examples with 4 year plus timelines to fully establish the working relationships required to deliver successful primary care homes. These in turn however saw benefits through the collective management of resources and a reduction in health inequalities. As with the examples in the South West that were considered, the focus of building a successful PCN was very much around the importance of building a coalition of the willing through relationships, trust, understanding of the roles of others and inspiring the PCN team via rapid cycles of improvement to make small changes. Analysis of 263 Primary Care Home Sites showed an increase in the percentage of clinical non-GP staff, patient satisfaction and a reduction in A&E admission rates as teams collaborated beyond traditional boundaries and focused more on prevention. It was recognised that the model in rural settings would need to be different from urban settings, with variation in benefits such as the sharing of back office and clinical support services or harnessing the richness of the community assets such as physiotherapy resource.

Training hubs, previously known as CEPNs, have been funded by Health Education England in each STP. Some training hubs are more mature than others but all should be linking in to PCNs to offer support via workforce planning, placements and rotational posts. Training hubs are also working to address the GP workforce issues via a next generation GP programme, post CCT fellowships and GP career lead roles amongst other initiatives. While ongoing funding into 2020 and beyond for training hubs is not yet confirmed they aspire to both innovate and recruit into primary care careers.

The Clinical Senate also considered the importance, as PCNs mature, of developing services in those areas outlined as national priorities in the Long Term Plan such as mental health and cancer. One such compelling example was given for mental health services where at the 30-50k scale, provision had been tailored to the population, allowing PCN clinicians to better understand and provide support for the mental health issues for their population, creating more appropriate case-loads for the specialist mental health teams.

There are several good examples of existing Primary Care Homes, now becoming PCNs, in the South West to look to. Success has reportedly hinged on the freedom of that network to lead for its community, a growing non-GP clinical workforce, the permission to fail as it develops and the ability to identify local assets such as schools, charities, libraries and youth groups.

Patient engagement, co-design and seeking out the seldom heard at the local level of the PCN is also identified as key and PCNs are being encouraged to ask patients to share their experiences and ideas for change in order that the community is well understood and they in turn are able to and are supported to access the right services at the right time, in the right place.

There is some tension between the concepts of personalised care and unwanted variation, with concern that population-based delivery at this scale will increase variation. This places emphasis on the importance of local leadership, relationship building within and beyond a PCN geography and supporting the right access for patients. Where services vary this should be for the benefit of population health.

Recommendations:

Primary Care Networks, if successful, will make an important contribution to the development of high-quality health and social care services and care pathways in the South West. Their success will depend on the robustness and maturity of the relationships that develop between all professionals within the network and the strength of their partnerships with other elements of the health and social care system. However, they should not be viewed as the panacea to all challenges in primary care, notably the current workforce and access issues.

There is strong evidence around the proposed coverage for PCNs of a 30-50k population size that is set within the context of wider evidence around place-based systems of care. This evidence demonstrates that at this level the scale is great enough to offer a range of services and benefit from economies of scale whilst small enough that meaningful staff and patient relationships are maintained. The development of Primary Care Networks offers a useful framework for local clinical leadership for primary care innovation on a small and meaningful scale, in the context of developing Integrated Care Systems (ICSs)/STPs both within the South West and across the current 44 STP footprints nationally.

Key Recommendations are as follows:

1. **Workforce Skills**
    a. The success of Primary Care Networks will centre around the workforce they comprise. Each network should consider workforce from a system perspective rather than an individual organisation perspective.

b. PCNs will need to focus on the skills required to deliver services within a multidisciplinary team rather than historical professional roles and look for employment models that facilitate working across organisational boundaries. The additional resources allocated to PCNs are limited so models of working will need to look at imaginative approaches to utilise the existing workforce.

c. PCNs should approach their STP training hub for support with workforce planning, training or placement initiatives. Social prescribers will have a key role in signposting and training for consistency may be required. CCGs, STPs or ICSs should be sharing any successful pilots for workforce or service delivery innovation.

d. The South West Clinical Senate's previous recommendations on community pharmacy http://www.swsenate.org.uk/wp/wp-content/uploads/2019/01/2019-29-01-Senate-Recommendations-Community-Pharmacy-final.pdf and workforce http://www.swsenate.org.uk/wp/wp-content/uploads/2018/04/2017-12-06-Senate-Recommendations-Workforce-FINAL.pdf may be helpful to refer to when considering the PCN workforce as they focus on how best to use community pharmacists as an asset and the importance of retention in maintaining a sustainable workforce .

2. Relationship Building

Evidence from Primary Care Homes demonstrates the importance of robust and meaningful relationships between team members. Developing these relationships will take time. Clinical Directors of the PCNs and CCGs and others supporting their development should consider the organisational development programme that sits alongside the emergence of the PCNs

Partnership working with other organisations in the system delivering health and social care to the same population as the PCN will be key. These will include community services providers, acute trusts and the voluntary sector. They should be engaged early in the development of PCNs, particularly existing community providers.

3. Clinical Leadership

The role of Primary Care Network Clinical Directors, currently being confirmed across the South West, will be key to the development of PCNs.

Given the limited time allocated to these roles, CCGs, NHSE and the training hubs should develop a support and training programme for clinical leads which supports them in promoting models of distributive leadership.

4. Information Sharing

The ability to share information is key to the construct of a Primary Care Network. Teams cannot be asked to work differently, in an integrated fashion and improve the quality of care without being able to share information.

PCN member practices will be expected to sign up to a data sharing agreement as part of their DES and this will include clinical patient data, as the enhanced hours and improved GP access will

necessitate practices seeing patients from other PCN practices. These should be developed as much as possible. Data collection to record outcomes should also be built into PCN ways of working.

NHSE must facilitate and support progress with wider information governance solutions to ensure that all clinical teams can access patient notes and booking systems as a minimum and reduce the limitations around intra-operability.

5. **Population Health**
   There is clear evidence around the size of PCN groupings to deliver healthcare to a population of 30 – 50 000. Applications to develop PCNS that cover populations that fall significantly outside this range should have a clear rationale for doing so.

   If PCNs are considered to be the building blocks for improving population health, population health information, produced by PHE and local authorities, will need to be published aligned to the geographical boundaries of the PCNs and available by 2020. Population data mining software should be used to identify at risk patients and then deliver targeted health interventions in partnership with secondary care and community specialists.

   An early milestone or PCNs should be for them to be supported to create the "map" of the community assets in their area and their strategy for engaging them in the development of the network.

Next steps

As the Primary Care Networks across the South West are confirmed, the intention is that these recommendations will be shared with the newly appointed PCN Clinical Directors, along with PHE, HEE and South West CCG and NHSE Primary Care leads to use as guidance and a reference tool as PCNs consolidate and to inform conversations with commissioning colleagues. They will also be shared with other Senates at a national level to cascade to PCNs as appropriate.

These recommendations should be used as a reference tool to help to set direction as new PCNs are consolidating, support Clinical Directors in any negotiations, highlight priorities and where support is needed, flag limitations as necessary and encourage consistency in the interest of clear patient pathways.

Pre-reading

1. **BMA Primary Care Network Handbook**
   https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/committees/gpc/gpc%20england/pcn%20handbook.pdf?la=en
2. **GP Contract Framework**
   https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf
3. **Closing the Gap – Nuffield Trust Workforce publication**
   https://www.nuffieldtrust.org.uk/files/2019-03/heaj6708-workforce-full-report-web.pdf
   Richard Q. Lewis, Nav Chana, (2018) **"The primary care home: a new vehicle for the delivery of population health in England",** Journal of Integrated Care https://doi.org/10.1108/JICA-04-2018-0032
4. **The Long Term Plan** https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

The Council Agenda, Speaker slides and meeting notes are available at www.swsenate.nhs.uk