What are Primary Care Networks?

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https://www.kingsfund.org.uk/publications/primary-care-networks-explained

What are primary care networks?
Primary care networks (PCNs) form a key building block of the NHS long-term plan. Bringing general practices together to work at scale has been a policy priority for some years for a range of reasons, including improving the ability of practices to recruit and retain staff; to manage financial and estates pressures; to provide a wider range of services to patients and to more easily integrate with the wider health and care system.

While GP practices have been finding different ways of working together over many years – for example in super-partnerships, federations, clusters and networks – the NHS long-term plan and the new five-year framework for the GP contract, published in January 2019, put a more formal structure around this way of working, but without creating new statutory bodies.

Since 1 July 2019, all except a handful of GP practices in England have come together in around 1,300 geographical networks covering populations of approximately 30–50,000 patients. This size is consistent with the size of primary care homes, which exist in many places in the country, but much smaller than most GP federations. Around 50 networks, usually in very rural areas, will cover a population of less than 30,000, but most are bigger than 50,000.

How are they formed?
Most networks are geographically based and, between them, cover all practices within a clinical commissioning group (CCG) boundary. There are some exceptions where there were already well-functioning networks that are not entirely geographically based. Some networks cross CCG boundaries.

While practices are not mandated to join a network, they will be losing out on significant extra funding if they do not, and their neighbouring networks will be funded to provide services to those patients whose practice is not covered by a network. In some cases, where a single practice has met the size requirements of a network, they are also able to function as a network.

What will primary care networks do?
NHS England has significant ambitions for primary care networks, with the expectation that they will be a key vehicle for delivering many of the commitments in the long-term plan and providing a wider range of services to patients.

Primary care networks (PCNs) will eventually be required to deliver a set of seven national service specifications. Five will start by April 2020: structured medication reviews, enhanced health in care homes, anticipatory care (with community services), personalised care and supporting early cancer diagnosis. The remaining two will start by 2021: cardiovascular disease case-finding and locally agreed action to tackle inequalities.

To do this they will be expected to provide a wider range of primary care services to patients, involving a wider set of staff roles than might be feasible in individual practices, for example, first contact physiotherapy, extended access and social prescribing. Networks will receive specific funding for clinical pharmacists and social prescribing link workers in 2019/20, with funding for physiotherapists, physician associates and paramedics in subsequent years.

They will also be the footprint around which integrated community-based teams will develop, and community and mental health services will be expected to configure their services around PCN boundaries. These teams will provide services to people with more complex needs, providing proactive and anticipatory care.

Primary care networks will also be expected to think about the wider health of their population, taking a proactive approach to managing population health and, from 2020/21, assessing the needs of their local population to identify people who would benefit from targeted, proactive support.

Primary care networks will be focused on service delivery, rather than on the planning and funding of services, responsibility for which will remain with commissioners, and are expected to be the building blocks around which integrated care systems are built. The ambition is that primary care networks will be the mechanism by which primary care representation is made stronger in integrated care systems, with the accountable clinical directors from each network being the link between general practice and the wider system.

How will the funding for primary care networks work?
Much of the new money for the NHS announced in June 2018 is directed at primary and community services, and a large proportion of this will be channelled through networks.

The main funding for networks comes in the form of large directed enhanced services payment (DES), which is an extension of the core GP contract and must be offered to all practices. This will be worth up to £1.8 billion by 2023/24. It includes money to support the operation of the network and up to £891 million to help fund additional staff, through an additional roles reimbursement scheme. The contract is between the commissioner and individual practices, but receiving the money for the directed enhanced services payment is contingent on being part of the network and the money will be channelled through a single bank account directed by the network.

Funding and responsibility for providing the enhanced access services, which pays GPs to give patients access to consultations outside core hours, will transfer to the network directed enhanced services payment by April 2021. In addition, a 'shared savings' scheme is proposed, under which primary care networks will benefit financially from reductions in accident and emergency attendances and hospital admissions. There will also be separate national funding to help primary care networks access digital-first support from April 2021, from an agreed list of suppliers on a new separate national framework.

What are the additional types of staff that will be funded?
The *Additional Roles Reimbursement Scheme*, part of the directed enhanced services payment contract, will fund 70 per cent of the cost of the specific new clinical roles, with the different roles coming in over the period of the contract, starting with clinical pharmacists and social prescribing link workers in 2019/20 (100 per cent of the cost of social prescribing link workers will be funded).

In 2020/21 the scheme will be extended to include physician associates and first contact physiotherapists, with community paramedics added in 2021/22. The funding is intended to cover only new staff rather than existing roles. Networks will have the flexibility to decide how many of each of the types of staff they wish to employ.

Who are primary care networks accountable to?
Practices are accountable to their commissioner for the delivery of network services. Practices will sign a network agreement, a legally binding agreement between the practices setting out how they will discharge the responsibilities of the network. Primary care networks can also use this agreement to set out the network's wider objectives and record the involvement of other partners, for example community health providers and pharmacies, though these partners will not be part of the core network, as that can only be entities who hold a GP contract.

It would be possible to remove a practice's entitlement to the directed enhanced services payment if the commissioner felt it was not delivering these services, in the same way a commissioner could remove a general medical services contract, though this is extremely rare. Each network has an identified accountable clinical director The main purpose of this role seems to be to provide a voice upwards to the wider integrated care system, and to be a single point of contact for the wider system, rather than to be accountable for the performance of the network or its constituent practices. The clinical directors are appointed by the members of the network.

What does the evidence show makes for successful collaboration in general practice?
Previous research by Fund found that collaboration in general practice was most successful when it had been generated organically by general practices over a number of years, underpinned by trust, relationships and support, and where there was a clear focus and agreement on the role of the collaboration (for example, whether it was to share back-office functions, provide community services or for quality improvement). Collaborations were less successful where there was a lack of clarity of purpose or engagement or over-optimistic expectations. There are also some technical issues including high costs of shared information systems or complexities around financial liabilities and premises which might need to be addressed.

Wales, Scotland and Northern Ireland have already implemented similar models which England can learn from. In Scotland, a key feature of the new GP contract has been the obligation to become part of a geographical quality cluster. These have been seen as variably successful, working well when they worked on similar quality improvement initiatives and less well when they covered a mix of urban and rural practices that faced different issues and had difficulties coming together to agree

priorities. The Welsh health boards have also established clusters of practices: a Welsh assembly inquiry into their operation found evidence of good work but highlighted a concern that the cluster model may be over-reliant on key individuals and that professionals are not being included in cluster work as much as they should be.

Primary care networks in England will need support to build the trust and relationships needed for successful collaboration, resisting attempts to be over-optimistic in what can be achieved in the short term. The scale and complexity of the implementation and leadership challenge should not be underestimated, and those leading primary care networks will need significant support if they are to deliver the ambitions set out for them.

What difference will primary care networks make for patients?
Primary care networks have the potential to benefit patients by offering improved access and extending the range of services available to them, and by helping to integrate primary care with wider health and community services.

Previous research on the impact of larger scale general practice on patient experience found mixed views. While some patients prioritise access above all else and are interested in the potential of larger collaborations to improve that access, others are more concerned about continuity and trusting relationships and are concerned these may be lost. Practices will need to work with their patient participation groups and the wider local community if they are going to address the needs of their local population.

What next?
Test-bed sites will be developed to test elements of the new contract, new service specifications will be developed and written, and the innovation and investment fund designed. A new developmental support offer will be available for networks as they seek to implement new roles and services. The GP contract negotiations for the 2020/21 contract will begin in the autumn and will include more details about the service specifications.