Primary Care Networks

Primary Care Networks: briefing paper for VCSE sector organisations

February 2020

National Voices

About this resource

The information in this resource is for any group or organisation in the voluntary, community and social enterprise (VCSE) sector, including umbrella bodies and networks.

It explains a new way in which health and care services are being organised locally across all of England: primary care networks (PCNs).

The main **purpose** of the resource is to explore how VCSE organisations might supply knowledge, expertise and training to help PCNs develop.

This could be significant in making sure the PCNs – as they are supposed to do – become *closely engaged* with their local population and focus on *what matters most* to individuals and communities.

About National Voices

National Voices is the coalition of health and care charities in England, working for person centred and community-based care to become mainstream.

Over the last eight years it has worked to build the evidence base for these approaches, to influence national policy to adopt them, and to promote and support them in local health and care systems.

It helped to produce NHS England and NHS Improvement's 'Universal, Personalised Care' delivery plan, published in January 2019 as part of the NHS Long Term Plan.

Under this plan, we have helped the PCN national programme to develop materials and resources for PCNs[1].

National Voices is a member of the Voluntary Sector Health and Wellbeing Alliance, a partnership that works on policy priorities, especially health inequalities, with NHS England and NHS Improvement and other national bodies.

[1] National Voices is a member of the NHS England and NHS Improvement advisory groups for 'Primary Care and System Transformation' and for the Primary Care Networks programme.

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Note on the text

This resource is intended to inform all kinds of VCSE groups and organisations, including those with little knowledge of healthcare policy.

This presents the challenge of managing policy jargon. Jargon terms are important to know because you will need them in order to have shared dialogue with NHS people and organisations.

We have tried to write about PCNs and their development in plain English – but then to reference the relevant piece of jargon by which the NHS describes the same things.

These terms are found in **purple text** with purple boxes below providing an explanation of the word or phrase.

We hope this is more useful than a separate glossary and will guide you through the sometimes complex language.

Other resources

As well as this briefing document, we have developed several other resources for VCSE groups and networks to help explain PCNs and explore why and how to work with them. These additional resources include a short leaflet and a slide deck, both can be found here.

SECTION ONE: About PCNs

What are PCNs?

Since July 2019 every area of England – and every person who uses health services – is covered by a local PCN. There are 1,250 of them.[2]

Your PCN is not a new 'organisation'. It is a coming together, over time, of all the primary and community care organisations that work with people in, or close to, the places where they live.

That means, usually, a group of GP practices, plus the community health services such as district nurses, the community mental health services, and adult social care (which is run by councils).

They will work together to make primary care more sustainable, join up people's care and aim to achieve better health and wellbeing.

Each PCN covers a population of around 50,000 people[3]. They have been given some extra funding through the NHS, mainly to employ new staff in new roles.

The contract to be a PCN is held by one of the member GP practices. Each PCN has appointed a 'clinical director' to lead its development.

Your own GP practice continues to exist in its current form and to do the work it previously did.

But by 'scaling up' general practice and plugging it into other front line services, PCNs can aim to achieve things that the previous model of care struggled to do – see below.

Box A: Key facts about PCNs

- 1250 PCNs in England
- Cover areas of around 50,000 people
- Each is led by a clinical director
- Some were started three or four years ago, but
- Most were established in July 2019
- Contract held by one of the GP practices in the network

[2] A very small number of general practices have not opted into a PCN and so the coverage is not quite 100%

[3] The size of their population is determined locally by adding up the lists of registered patients at the member GP practices. Most are between 40-50,000 people, but some are up to 70,000 people. A few, in rural areas where people are very spread out, may have less than 30,000.

Why might VCSE organisations be interested in working with PCNs?

PCNs are the most important part of a 'new care model' which will develop over the next 5-10 years under the NHS Long Term Plan, announced in January 2019.

The NHS describes many aims and responsibilities of PCNs, but some of the **most important for the VCSE sector**, and the people with whom we work, are as follows:

Care closer to home

People thrive best, and care can be most effective, if services help people in or near their homes.

At the same time as boosting primary and community care, the NHS aims to reduce the need for people to use hospitals, when they could be at home. This means less use of emergency care, and much less need for outpatient appointments.

Joined up care

The best outcomes are achieved when people's care is well coordinated, and their professionals and supporters work in teams.

By getting fragmented services to start cooperating, PCNs can better ensure that people get joined up ('integrated' or 'coordinated') care.

For example, your GP and your community nurse can be part of a team; and your physical and mental health needs can be planned for together.

Working with the population and changing services and support

PCNs are not expected just to join up existing care, though.

By bringing together all the people working with a local population, planners are able to look actively at all the health issues affecting that community, and plan to do things differently. This is called **population health management**.

Population health management: working with local populations, local health and care planners are able to understand the health issues affecting that community and plan to do things differently. For further information please see this animation and the population health management section later in this document.

Instead of waiting for people to get ill and turn up at the door of the service, PCNs will work with their communities to understand who needs help and support to stay well.

Working differently with people and communities

As PCNs learn about and begin to do 'population health management' they will also need to become good at the following things (which are described in more detail in Section Two):

- **Community engagement**
- **Tackling health inequalities**
- **Prevention**
- **Social prescribing and link workers**
- **Codesign**
- **Personalised care**

Community engagement: engaging with their communities to understand their needs and find out what works

Tackling health inequalities: contacting and learning about the groups who are least well served, or most vulnerable to ill health

Prevention: reducing ill health by supporting people earlier, often with the help of community groups and voluntary organisations

Social prescribing: schemes that give 'patients' time to focus on what matters to them, including aspects of their lives that may be affecting their health and wellbeing, and connect them to non-medical practical and emotional support.

Link workers: the people who work in social prescribing schemes. They are often part of a 'multidisciplinary team', which is a group of health care workers from different disciplines (such as physiotherapists, dieticians and speech and language therapists) who work together with patients on their treatment, care and support.

Codesign: designing care services *with* people so they better meet their needs

Personalised care: organising care services so that they can respond to 'what matters most' to each individual

VCSE organisations may hold the key to much of this community knowledge, engagement and involvement in redesigning care.

Ideally – over time – PCNs, their communities and VCSE sector organisations will learn to work together as equals on these challenges.

In short, the community would also be 'part of' the PCN, just like the statutory service providers (the NHS and councils).

This ideal state could be called **'coproduction'**.

Coproduction: a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation. (NHS England/Coalition for Collaborative Care)

How do I find my local PCN(s)?

You can ask your own GP practice which network they belong to.

To understand how PCNs fit across an area such as a city or county, you can contact your clinical commissioning group (CCG). You can find your CCG here (but note that many CCGs are in the middle of reorganisation).

Your local VCSE membership body – such as a Council for Voluntary Services – may also know; as might the local Healthwatch.

SECTION TWO: Supporting PCN development

In this section we ask whether (as well as engaging generally) VCSE organisations could formally support PCNs to learn and develop.

This will mainly be of interest to umbrella and infrastructure bodies, or to those individual VCSE organisations with the capacity to share knowledge, provide education, train staff, and support services to change over time.

Introduction

Through PCNs, primary and community care is going on a journey of change. Remember this fits within a ten year 'Long Term Plan' for the NHS.

Each PCN, and each local area, will map out that journey in their own way.

But there is a national description[4] (request access by e-mailing england.pcn@nhs.net) of the areas of development and knowledge they need to address. It is called the 'development prospectus'.

And local health systems have been given budgets to buy in learning support.

In general, support for improving the NHS is provided either by other NHS units and teams, or by other partners.

The aim of this briefing is to help VCSE sector organisations consider whether they could be among such partners. The work PCNs need to do, as outlined in the development prospectus, could be delivered with the help of the significant knowledge and expertise that lies in the VCSE sector.

This section describes how PCNs will develop, and how to think about becoming engaged as partners, consultants or trainers to help them learn.

A journey to maturity

PCNs had to be formed by July 2019 to take up the new contract.

But that does not mean they are ready to do all the things described in Section One.

[4] https://future.nhs.uk/connect.ti/P_C_N/grouphome

NHS England and NHS Improvement, and local health system leaders, recognise that PCNs must now go on a development journey over the next four to five years.

So, although there are some specific things they must do now under the contract [**'service requirements'**], they also have permission to plan, in stages, the way they will come together with other services and with their communities.

Service requirements: a contractual statement from NHS England and NHS Improvement to PCNs outlining what they expect PCNs to deliver.

This will vary widely from one PCN to the next, and between local areas.

To guide their development, NHS England and NHS Improvement has created a 'maturity matrix'. This is a way of describing how PCNs can move from one level of working to more advanced stages over time.

For example, when they are first established, they should be informing their local communities and taking the first steps to engage them.

When mature, in a few years, community voice should be embedded in everything they do.

The matrix is not a performance framework but a fairly loose guide.

It is likely that in local areas, PCNs will describe this development journey to 'maturity' in their own ways.

Development support

PCNs will be trying to do a lot of things that primary and community care does not do at the moment.

So, they will need external support to learn about these new areas, develop their knowledge and capacity, and change their culture, behaviour and care design.

This year and in each of the next three years, NHS England and NHS Improvement has earmarked extra money to pay for this learning and training.

This money is held by the lead clinical commissioning group in each of the partnership boards that cover wider local and regional areas of England, known either as STPs or ICSs (see Box B on how PCNs sit in the wider system).

PCNs were asked to analyse their own support needs in a **self-assessment** exercise. Their STP or ICS will then help to arrange learning support.

Self-assessment: a process by which PCNs have assessed how well they are able to deliver requirements of PCNs and identified priorities for development.

VCSE groups and organisations could potentially be a source of support; but we know it might be difficult to get access to this market.

Box B: The wider system - how do PCNs fit into health and care locally?

Under the NHS Long Term Plan, PCNs should be the most local, and community-facing layer of health and care services.

But they will work within a wider system, including 'commissioners' (who hold the local budgets to pay for services) and other 'providers' (such as the NHS trusts that provide hospital services, for example).

At this wider level, all the commissioners and providers in healthcare and adult social care have been asked to work together in partnerships to change services over the next five to ten years.

These partnerships are in 44 designated areas of England.

When they first came together they were called **STP**s – Sustainability and Transformation Partnerships.

As they become well developed they are renamed **ICS**s – Integrated Care Systems.

These partnerships should work together to look at all health and care needs across a bigger area, often including more than a million people, and make agreements about how everyone involved with that area is going to use their budgets and staff to work towards a healthier population.

Each partnership should have an approved five year plan for health improvement, to achieve the goals of the NHS Long Term Plan. That should include a strategy for primary care.

As well as this resource we will later:

- translate some of the relevant NHS materials into terms the VCSE sector can understand; and
- produce explanations for the STP and ICS boards on how to source support from our sector.

The development prospectus

The primary care development support prospectus has been developed by NHS England in consultation with a wide range of people, including frontline staff, CCG, STP and ICS primary care teams, development experts, NHS and local government

representative and professional bodies, and voluntary organisations. The prospectus, crucially, was developed alongside those that are now using development support to ensure it met their needs.

Alongside specific support for PCN Clinical Directors, the development support prospectus sets out six development support domains (specified areas of activity or knowledge) that PCNs will want to access as they develop and mature.

Here we describe some of the most significant domains from the VCSE sector's viewpoint.

You may wish to think about whether you could supply knowledge, training or learning support to PCNs in these domains.

Supporting collaborative working (Multidisciplinary Teams)

This domain states that PCNs will only succeed if they look out to partners - not just other providers, but patients, their carers and the wider community. It's about creating a joint model of personalised care.

In other words, it is about changing the way care is delivered so it is more responsive to each individual, with care based around 'what matters to you'.

A comprehensive model for personalised care is described in great detail in 'Universal, Personalised Care' – published as part of the NHS Long Term Plan.

Briefly, it means involving patients in making shared decisions and in creating and owning a personalised care plan, so that they can set out their own goals. Their treatment, care and support can then be organised around these goals.

People may be referred onwards to community-based groups and organisations who can help with non-medical needs such as benefits and finances, befriending, or health-supporting activities in the community. This is called **social prescribing**. Social prescribing link workers are employed within PCN multi-disciplinary teams to work on what matters most to people and connect them to community support.

Some people with a disability or a long term health condition might be offered a 'personal budget' to buy and direct their own support.

Professionals and services should be aiming to support 'self management' -- meaning that they help people to develop the *knowledge, skills and confidence* to manage their lives, including their health and their long term health conditions.

Population health management

This domain is about moving from a focus on managing sickness to a keeping people well. Population health management is about using current and historical data to improve health and wellbeing, both now and in the future. By using data systematically, PCNs can better understand and anticipate the needs of their local

population, so that services can be directed and act as early as possible to keep people well. This means that care can be provided proactively rather than reactively. It emphasises understanding the population's health needs through data. This can be:

- NHS or social care data about people using services;
- data about the things that affect health locally [**'social determinants'**] such as housing, transport or incomes; or
- insight from what people say locally about health and wellbeing [**'qualitative data'**].

Social determinants: the conditions in which people are born, grow, live, work and age.

Qualitative data: descriptive information about characteristics that are difficult to define or measure or cannot be expressed numerically such as feelings or emotions.

PCNs should become able to use this data and insight to understand inequalities; tackle the root causes of ill health and prevent further ill health; and work with partners and communities to target support and services to identified groups.

Social prescribing and community development

NHS England and NHS Improvement is paying for every PCN to have access to a 'social prescribing link worker' (see Box C: Link Workers).

From the PCN's point of view, link workers will be the mechanism through which social prescribing will be delivered. Social prescribing link workers will support people to connect with community groups and organisations, based on what matters most to the person.

This domain of learning is therefore about understanding the value of referring people to support; evaluating its impact; and developing the role of the link worker.

But PCNs, with their system partners, should also think about how to put this mechanism in the context of the local community, including:

- finding out about groups and organisations that could join in to provide support;
- establishing relationships in the VCSE sector;
- exploring how the community can be strengthened to support people's health and wellbeing, for example by funding new groups or activities.

Box C: Social prescribing link workers

Each PCN has, as part of its contract, been given funding to employ a 'link worker'.

The link worker is part of the PCN team. Their role is to receive individuals who are referred by any agency in the network, spend time listening to and understanding the individual and their health-related challenges, and help them connect to community support, including introducing them to local groups.

In this way NHS England and NHS Improvement aims to invest in making 'social prescribing' more formal and systematic, especially in areas where it has not so far developed: see the NHS guidance to PCNs about this role.

Link workers can be employed directly by the network or a constituent GP practice; or they could be employed and managed within a community organisation partnering the network.

However, the contract and funding requirements can be complicated to manage for either situation. Those who want to understand these requirements in more detail should check the contract specifications.

NHS England has produced a social prescribing reference guide for PCNs and provides a range of resources, training and support for link workers.

The National Association of Link Workers provides a membership body for these staff and also offers a checklist and code of practice to set the role up for success.

SECTION THREE: What to do next

Individual VCSE organisations

Think about your 'offer'. Could you support learning and development in your local PCNs?

Remember, the most likely areas where the VCSE sector could help are:

- community engagement – concepts, methods and local outreach;
- health inequalities – identifying and getting to know local groups and communities that have poorer health and/or access to services;
- social prescribing – how to map the strengths and resources in the local community; how to work with the community sector to establish or develop referral schemes;
- personalised care – how to identify what matters most to individuals and groups; tools, techniques and interventions that can support person centred care.

Your **offer** of support or working together might include:

Awareness raising – helping clinical teams and support staff to understand health, wellbeing and access to services from the point of view of the community

Knowledge transfer – discussing 'how to' do the things described above, and providing evidence or other tools

Workshops, roundtables or other events – to bring the community, or specific groups, into dialogue with the PCN

Training – helping PCN staff gain the 'knowledge, skills and confidence' to do the things described above

Network. Find out who else in the VCSE sector might be wanting to work with PCNs.

Unless you are a recognised training organisation with existing contacts in local health services, you might find it difficult to get noticed.

Use local networks and contact your VCSE infrastructure partner (such as your Council for Voluntary Services) to see if other organisations are wanting to get involved, and discuss working together.

Plug into the wider health partnership (the STP or ICS). The lead CCG in each of these partnerships holds the budget to pay for PCNs' development support.[5]

Ask your local or regional VCSE sector infrastructure body for help to contact the responsible person in the STP/ICS to find out how the sector can be involved in training and support.

VCSE infrastructure bodies

The health service is yet again changing its structures and its point of engagement.

You will need to consider, in the round, what you need and have the capacity to do to engage with both the STP/ICS level and the PCN level.

It is worth noting that PCNs are based around a relatively 'rooted' and long-lasting part of the NHS – GP practices. And that they have the potential to engage all frontline providers more closely with their communities.

In many areas social prescribing may already be under way and may be the priority for VCS engagement.

But it is one of several aspects of community engagement that PCNs will in due course have to negotiate.

It would therefore be useful to:

- find one or more of the PCN clinical directors (CDs) who are willing to have regular dialogue about PCN development;
- establish links directly, or through regional voluntary sector bodies, with the people at STP/ICS level who are leading on PCN development;
- talk to your CCG about how they intend to support PCNs;
- convene discussions among your members and networks about who can and wants to be involved in providing learning support to PCNs.

Make the market. Bring everyone together to make relationships.

Both primary care leads within CCGs and coordinators of the voluntary and community sector have told us that 'marketplace' events or 'forums' – where all the VCSE organisations who might have a support offer to make can meet with people from PCNs, the CCG and other care organisations – have proved useful in starting up the relationships you might need.

[5] Note also that CCGs have the legal ability to provide grant funding to VCSE sector organisations: see the bite-size guidance https://www.england.nhs.uk/wp-content/uploads/2015/02/nhs-bitesize-grants.rb-170215.pdf

Remember

PCNs are on ‘a marathon, not a sprint’. It is a development journey over five to 10 years.

You may find that many of the new PCNs are not ready yet to commit to working with communities. The STP/ICS will have the ‘helicopter view’ of which ones are the most ready – these leaders may need your support and help to bring their peers and colleagues along.

You may not find your support offer is immediately taken up – and funding may be scarce. CCGs, PCN clinical directors and VCSE coordinators tell us that the future potential to work together depends on the initial founding of good relationships.

The steps you take now to consider and prepare support offers, to collaborate with others, to build contacts and intelligence, and to understand the needs and challenges that PCNs and their clinical directors face, will prepare the way for future work over coming years.

Things to bear in mind when working with PCNs:

- they are not new ‘organisations’ – they are an arrangement between existing care providers;
- they don’t have a lot of ‘managing’ staff so it may be hard to get time to talk to them;
- they don’t have big new budgets – just a little bit extra for employing new staff and extending some services;
- they *do* need to talk to their local communities and voluntary sector, *but* they may not feel confident or ready in the first year;
- they *are* clinically led – usually by GPs – so you if you want to have good dialogue you need to take time to understand how clinicians see the world, and shape your ‘offer’ to solving ‘their’ problems;
- they don’t hold a budget to buy in learning – the budget for PCN learning and development is held by the STP / ICS on their behalf, so commissioning may not be direct.

Apapendix one: the various forms of organisation in general practice

PCNs are not the first attempt to join GP practices together or to get them to work at a bigger scale.

In response both to the pressure of growing demand from patients, and the difficulty of finding and keeping enough staff, many practices have banded together in different ways. We have used explanations from the British Medical Association for this section.

Some common forms are:

- GP federations: these are local voluntary arrangements between practices to do some of their work jointly. See more here. They may just have a memorandum of understanding about sharing some work; or they might together form a business organisation to get larger contracts or extend their services to patients. Federations are now trying to work out their relationship to PCNs. In some cases, PCNs may ask the federation to take on certain functions – possibly including employing the link workers.
- Hubs: GP practices cooperate to make sure there is one place that can take patients that some practices are struggling to see. For an urgent appointment you might be seen by a different practice to your own. See more here.
- Merged practices: practices may merge into a single business, or one might take another over, often because the weaker practice can't find enough GPs or carry out the full requirements of its contract.
- 'Super-practices': these are very large practices formed by the voluntary merger of many small ones. They might lie across a single geographical area, or they might cover patches of the country that don't physically join up.

By creating a large scale, they can 'centralise' their business functions, bid for bigger contracts, add new services and change the way that staff are managed.

One particular form of joined up practice, the Primary Care Home (PCH), paved the way for PCNs, PCH sites began four years ago and there are now over 200. They emphasise partnerships not just between GPs but with other service providers; aim to serve a population between 30-50,000; and focus on person centred care and population health.

It is worth finding out whether any of your local PCNs are Primary Care Home sites, as they may have more experience and readiness to work with community organisations.

Acknowledgements

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National Voices

National Voices is the leading coalition of health and social care charities in England. We work together to strengthen the voice of patients, service users, carers, their families and the voluntary organisations that work for them. We have more than 160 members covering a diverse range of health conditions and communities, connecting us with the experiences of millions of people.

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