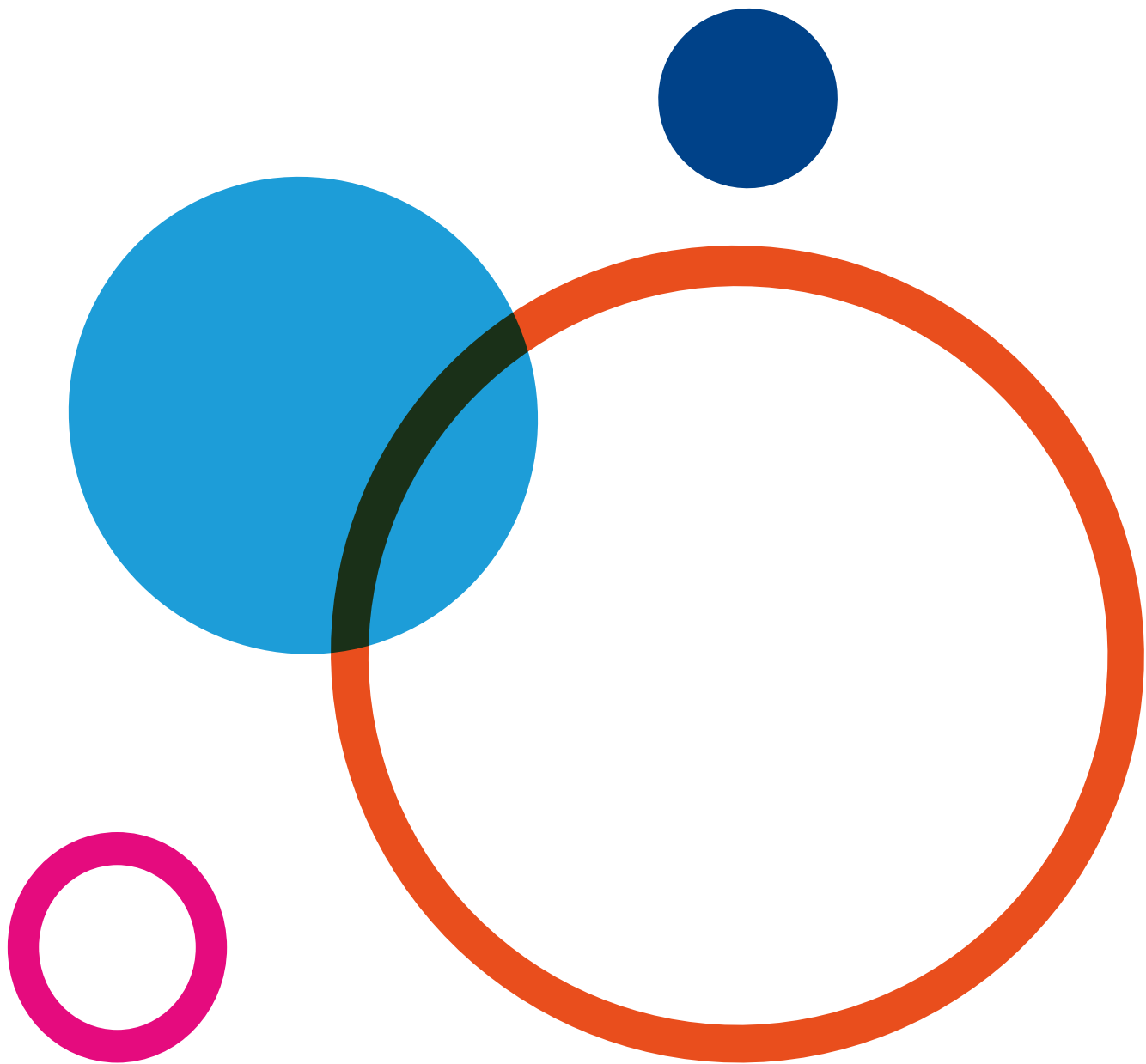


Primary care networks

One year on



About the PCN Network

The PCN Network has been established by the NHS Confederation to support primary care networks (PCN) and to ensure they are effectively represented within the health and care system.

Through the PCN Network, we aim to:

- be a strong national voice for PCNs across the system
- influence national policy and debate and ensure that expectations are informed by insights from PCNs
- promote the role of PCNs within the NHS Long Term Plan and their essential role, both now and in the medium term
- ensure PCNs have access to the information, advice and support they need to grow and fulfil their potential
- ensure that PCNs have influence within local health and care systems, through links with other NHS Confederation networks
- work with other partners and stakeholders to develop a vision of the possible for the future.

Read more at www.nhsconfed.org/PCN-Network

About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

Find out more at www.nhsconfed.org and follow us on Twitter [@nhsconfed](https://twitter.com/nhsconfed)

Foreword



Ruth Rankine

Director
PCN Network

The last 12 months have presented a series of opportunities and challenges for PCNs. The sense of excitement at creating something new with a real focus on supporting local communities and getting to grips with health inequalities has, very often, been overshadowed by contractual requirements and what has been perceived to be a ‘tick-box’ exercise. With record investment in primary care over the course of the NHS Long Term Plan, some of this is inevitable but equally risks eradicating enthusiasm from the leaders and innovators we are relying on to make PCNs a success.

The extent to which PCNs have progressed has been contingent on good leadership capability, a history of strong local relationships and a clear vision of what they want to achieve and how to use the contract as the vehicle to deliver it.



Dr Graham Jackson

Senior Clinical Adviser
NHS Confederation

There have no doubt been obstacles. The launch of the draft specifications before Christmas caused uproar, although the principle of more active engagement and a closer, more open relationship with the front line was welcome. And then, of course, COVID-19 – the greatest health challenge the NHS has faced in its 72 years. But in spite of such obstacles, and some would argue as a result of, many PCNs have been able to make significant progress.

Looking forward, there are new challenges ahead for PCNs, but these also lead to opportunities. With new health legislation widely expected to come in the next 12 months, the health and care landscape may be about to change fundamentally as the focus turns to integrated care systems and place-based working. There has never been a more important time for PCNs to be part of the wider conversation about the transformation of services. And to do this effectively, the PCN Network will continue to push for more time for clinical directors and their managers to engage at a strategic level, and greater freedom and autonomy to respond to the needs of their communities. Only then will we retain strong leaders in clinical director roles and get the innovation in primary care that we have seen a glimpse of in the response to COVID-19.

We will continue to work on your behalf to drive a greater balance in freedom and accountability to ensure that PCNs are able to both drive local change and influence national decision making.

Key points

- July 2020 marks the one-year anniversary of primary care networks (PCNs) being established across England. To recognise this, the PCN Network has assessed their progress so far through engagement with networks across the country.
- As this report sets out, the picture nationally is one of variability. At the top end of the spectrum, there have been notable success stories of networks delivering tangible benefits for the health of their populations. However, these are likely to be in areas where there has been a history of established collaborative working. For others, simply getting a PCN up and running effectively has been an achievement.
- During their first year, progress has been made in several areas. Many PCNs have significantly expanded their use of technology, allowing more patients to be seen during the COVID-19 pandemic, and built strong new relationships with other partners across primary care and the wider system. Equally, those recruited through the Additional Roles Reimbursement Scheme have, in many networks, played a key role in helping to ease workload pressures and forge strong links with other stakeholders, such as in social care.
- There have, however, been some significant challenges. In some instances, local stakeholder relationships have been strained. Relations with some clinical commissioning groups, for example, have at times been difficult, often due to lack of communication or perceived micro-management. Workload has also been an issue – for many PCNs it has been heavier and more stressful than anticipated, with much of this work falling to the clinical director.

- Looking ahead to the next 12 months, this report identifies several areas in which there will be opportunities for PCNs to develop. But to take advantage of these opportunities, PCNs will require support from NHS England and NHS Improvement (NHSEI) and the government. To enable this, we have focused a set of asks around three key areas:

Influence and autonomy

There is a clear desire among PCNs to have a voice at national level in determining their future and to have a central role in 'reset' locally as services begin to look beyond the COVID-19 emergency response phase.

One size does not fit all

A 'one size fits all' approach will not be effective considering the huge variation in demography across PCNs. There needs to be flexibility for clinical directors to design and deliver services that meet local needs and to manage their network in such a way to support this.

Promoting integration in all areas

The shift towards integrated care must be accompanied by streamlined processes for clinical directors. The role for PCNs in the wider system must also be made clear.

- Through ongoing engagement with PCNs, specifically including clinical directors and network managers, the PCN Network looks forward to supporting both NHSEI and the government in delivering these asks. We intend to work collaboratively with both to ensure that the PCN voice is heard and that their role in systems is clear and widely understood over the coming years.

Background

This month marks the one-year anniversary of primary care networks (PCNs) being established across England. PCNs were introduced last July with high expectations. Their stated aims included the stabilisation of general practice, the dissolution of the historic divide between primary and community health services and above all, to help reduce health inequalities. Meeting these expectations has been impacted by COVID-19, which in some respects has hindered the progress of PCNs. However, this has not been the case in all areas and this report highlights some of the progress made in spite of, and in some instances because of, the pandemic.

As we look ahead, the delivery of many of the ambitions of the NHS Long Term over the coming years – from addressing health inequalities to improving prevention to supporting people to age well – will depend on the success of PCNs.

The PCN Network has therefore sought to mark the first anniversary by assessing their progress so far. To draw out the achievements of, and challenges for, PCNs in their first year, we convened our clinical director board to identify some of the trends across the networks in their regions. These were then tested and refined through a consultation with clinical directors and PCN managers nationwide.

Through this engagement, we have heard how in many areas the introduction of PCNs has led to significant changes in culture across primary care. However, we have also heard about the obstacles they have faced and the overwhelming pressure that has been placed on the shoulders of staff. This has meant that in some areas PCNs have yet to make significant impact.

This report sets out the key themes that have emerged, concluding with a look ahead to the next 12 months for PCNs. It outlines where PCNs believe the opportunities lie for their networks and a set of asks of NHS England and NHS Improvement and the government to consider what we believe would enable PCNs to reach their full potential.

The first 12 months

What has gone well?

Use of technology

Digital platforms, including those offering patient/population management and virtual group conversations, have expanded significantly over the last year. These have helped to improve communication within and between networks and have been especially beneficial in areas where practices are not geographically close.

Clinical directors have noted that the pace of digital transformation has accelerated significantly across the country during COVID-19. We have heard how those GPs who for many years may have been resistant to using technology for consultations have realised the value it can offer, such as by enabling remote consultations and allowing more patients to be seen. The [Royal College of General Practitioners](#) found that over 70 per cent of GP consultations in England were carried out face-to-face prior to the COVID-19 outbreak, yet within weeks of the pandemic the figure had dropped to 23 per cent.

“COVID-19 has massively improved digital working. Necessity is the mother of invention.”

Clinical Director

Spotlight: Apps to improve care

In south east London, four PCNs have worked with their GP federation and private sector digital providers to develop an app in response both to COVID-19 pressures and the existing desire to improve multidisciplinary working across primary care.

The app, which tracks patient flows between services and staff resource, has been built around the needs of PCNs. It recognises, for instance, the complexities of the Enhanced Healthcare in Care Homes service specification and the need to monitor the flow of residents. This has allowed PCNs to:

- have a helicopter view of all patients in the system
- see information on individual patients, including what treatment or care pathway they are on and where further support is required
- manage access and restrictions on patient information for different stakeholders, such as GPs and care workers.

Local stakeholder relationships

We have heard that in many areas relationships across primary care have improved significantly, with some stakeholders reporting that before PCNs there was little or no interaction between practices, as well as between general practice and other local providers. Multidisciplinary teams have generally been effective in improving patient care and using the expertise of the wider NHS and voluntary sectors, as well as local authorities.

Spotlight: Getting to know partners across primary care

Before PCNs, collaborative working between practices had in many areas been limited. This was especially the case in rural areas, where practices have not had the benefit of being located close to each other, as is often the case in urban areas.

A clinical director in a rural area of south west England told us that in her PCN there was a big challenge for the stakeholders within the network to get to know each other. Strong relationships and trust are a fundamental prerequisite for the success of PCNs and cannot be created overnight. This has been a factor in explaining the quick progress of some networks in their first year

and the slower progression seen in others.

For some PCNs, weekly meetings between a wide range of stakeholders within the network (including from public health and social care) have proved to be essential in fostering trust and establishing ways of working. One clinical director told us that shifting these meetings to video conferencing as a result of COVID-19 has been hugely beneficial. It has saved people having to travel to meetings, simultaneously saving time and incentivising attendance. This has been particularly helpful for rural PCNs.

The fact that practices are now having ongoing contact with each other, and importantly with others across health and care settings, is in many areas an achievement considering where they started from last July.

“Our PCN has been working very closely with our community teams and the voluntary sector, with lots of joint working and forging new ways of working. We have been identifying gaps in service and how we can fill these, reducing double working and increasing efficiencies. There is much better communication.”

Clinical Director

Professionals in extended roles

In many PCNs, the professionals recruited through the Additional Roles Reimbursement Scheme (ARRS) have played a key role in their networks, helping to ease workload pressures and forging strong links with other stakeholders, such as in social care. These have notably included social prescribers and pharmacists.

Spotlight: Social prescribers and the ‘public face’ of PCNs

Social prescribing link workers, otherwise known as social prescribers, have been instrumental within many PCNs in helping patients and their carers to navigate the voluntary and community services environment. This has largely occurred through signposting, but also referring patients to appropriate voluntary, community and social enterprise (VCS) services.

We have heard from some clinical directors that their social prescribers have essentially

become the ‘public face’ of their PCN, in that they are patients’ point of contact throughout their care. For many clinical directors this has been very useful, allowing them to focus on clinical work. During the pandemic, we have heard that social prescribers have been particularly helpful in leading engagement with the patients on shielding lists who have in many cases needed practical, rather than clinical, support.

“There has, as yet, been little impact from extended roles. Recruitment, including problems establishing the practice’s baseline, has been problematic.”

Clinical Director

That said, however, it must be stressed that PCNs’ ability to take advantage of ARRS staff has been variable. For some, this has been because there has not been time or resource for supervision of ARRS staff. The National Association of Link Workers has in a [recent report](#) highlighted, for instance, that 29 per cent of social prescribing link workers are considering resigning in the next year due to lack of clinical supervision and/or support.

However, there have also been problems for some around recruitment. This has partly been a geographical issue as the funding provided to PCNs has been consistent across the country (for example, no additional funding to cover London weighting). This has made recruitment difficult for networks in the capital. Equally, there is not an equal spread of available workforce nationally meaning that some PCNs have struggled to recruit in areas where there is simply a lack of supply.

Challenges

Local stakeholder relationships

The section above illustrates how the development of new relationships with local stakeholders has been a strength in many PCNs. Yet for other, this has been a challenge. Relations with some clinical commissioning groups (CCGs), for example, have at times been difficult, often due to lack of communication or perceived micro-management.

We have also heard that CCGs' support during COVID-19 has been variable and in some cases quite limited for many PCNs. This has made dealing with issues such as personal protective equipment (PPE) and shielding lists more difficult.

“We had a new CCG starting during the pandemic [and] the communications have been poor.”

Clinical Director

Spotlight: Time needed to develop relationships

We have heard from some clinical directors that it has been difficult to improve relationships with those more widely than general practice, given time constraints. With clinical directors having to prioritise, there has been pressure to focus on relationships between practices (particularly in light of recent uncertainty around the network contract direct enhanced service – DES).

This, in turn, has left little time for clinical directors to spend on developing the relationships across the community and voluntary sectors, which long term will be key to PCNs' success.

The issue of clinical directors' lack of time is something that we highlighted earlier this year in our report [Equipped For Success?](#).

Workload

The workload for PCNs has been heavier and more stressful than many anticipated, with much of this work falling to the clinical director. Huge pressure has been put on those working in PCN teams, exacerbated by COVID-19, and many clinical directors are concerned that it is not sustainable. Specifically relating to COVID-19, a real challenge for PCNs has been ensuring that staff have had access to PPE and testing.

Issues around workload have been most acute in PCNs where teams are small. As mentioned above, this may be due to problems with recruitment or lack of local workforce supply. However, it is often due to a lack of dedicated management support. During their first year in the role, many clinical directors have had no administrative help and have had to carry out basic tasks. This has led to frustration that they have not been able to demonstrate the strategic leadership they had envisaged.

Over recent months, managers have increasingly been employed to help ease the pressure on clinical directors. The non-clinical leadership will be essential in moving PCNs forward, and adequate investment in this capacity and capability is necessary.

For the reasons outlined above, and given that we previously found that over half of clinical directors are in their first clinical leadership role, concerns have understandably been raised around [burnout among clinical directors](#). If we are to address the high level of turnover among clinical directors, then they must be given further support.

“Pressures have not reduced yet and may rise again over the winter. We are still firefighting and have no opportunity to increase patient participation.”

Clinical Director

Current status

The overall picture across PCNs after 12 months is one of real variability. At the top end of the spectrum, there have been notable success stories of networks delivering tangible benefits for the health of their populations. However, as outlined above, these are likely to be in areas where there has been a history of established collaborative working. For others, simply getting a PCN up and running effectively has been an achievement. How such PCNs cope with delivering the new service specifications set out in the DES for 2020/21 remains to be seen, but many clinical directors are anxious.

There is still a good degree of optimism across PCNs a year on from their inception.

That said, overall, there is still a good degree of optimism across PCNs a year on from their inception. For many, COVID-19 has brought practices together and clinical directors have spoken of how essential their PCN has been in coordinating the local response to the pandemic. More integrated, collaborative working at neighbourhood level has certainly had positive implications for populations and there is enthusiasm among clinicians about new ways of working that have been established. This has laid a solid foundation on which PCNs can move forward, provided they are given the right ongoing support.

It must be noted, of course, that there remains a real risk of a second wave of COVID-19 infections and localised outbreaks also have the potential to significantly disrupt the progress of PCNs over the coming year. As the next section outlines, key to allowing PCNs to be prepared for this will be increasing both flexibility and authority for clinical directors.

With regard to where PCNs would like to have made more progress, clinical directors have spoken of concerns around recruitment, with many hoping that they would have taken on more extended staff such as physiotherapists and social prescribers. They also raised the issue of autonomy, with a sense among clinical directors that they would like to have had more control over how they meet the needs of their local population.

The next 12 months

Opportunities

Embedding technology

COVID-19 may have represented a turning point for the use of technology within PCNs and across primary care more broadly. There is an opportunity to embed new ways of working over the coming months, simultaneously improving accessibility to services for populations and enabling clinicians to use their time more efficiently. This would also help to create a greener NHS, with fewer patients needing to travel to appointments and ease pressure on estate.

“We need shared IT for true integration with community teams!”

Clinical Director

For such reasons, we support the British Medical Association’s recent report calling for ‘a rapid rollout of appropriate, safe, reliable, robust and secure digital technology and consultation software’. Over the coming years, technology that enables collaboration and the sharing of data will be key to PCN working.

That said, a valid concern among some is that the growing use of technology should not undermine or replace face-to-face patient contact. Equally, there must be recognition that not everyone has access to, or can easily use, new technology and PCNs will need to be able to adopt a more flexible approach to access.

Directing local recovery and reset

The health and care system is starting to look beyond the initial emergency response to COVID-19 and PCNs could, and should, have a central role within local systems as they begin to plan recovery and reset. Of course, it remains to be seen whether we see a second peak in the pandemic. However, there is a sense across many PCNs that the progress made in promoting collaborative working so far will put them in a better position to respond should a second wave hit.

At the time of writing, it is expected that new primary NHS legislation will be forthcoming by the end of the year. This should embed a place-based approach to health and care collaboration and formalise

PCNs' role within systems, in recognition of the NHS Long Term Plan's commitment for PCN representation on integrated care system partnership boards.

Increasing autonomy on workforce

As mentioned, those in extended roles have proved that they can cope in a crisis and take on increased responsibility in managing and delivering care. While there will be an ongoing need to develop and supervise those in such roles, there is an opportunity for PCNs to harness this growing autonomy, in turn delivering greater flexibility in responding to local need. There is also an opportunity to give clinical directors more autonomy over the roles they need within their workforce to best meet the needs of their population and that means a more flexible Additional Role Reimbursement Scheme.

Clinical directors and their teams need to be given the freedom to fully use and maximise their competences in order to provide clinical leadership at neighbourhood and place levels.

“Locally we are not considered to be as important as other providers; we are being sidelined and our representation at ICP and ICS level has been marginalised. The PCN voice must be mandated centrally into all systems.”

Clinical Director

Increasing community engagement

With pressures relating to the emergency response to COVID-19 subsiding, there is an opportunity for PCNs to have conversations with patients and the public about what is working well for them and what can be improved. As PCNs look ahead, future working should also involve building on communities' responses to the pandemic, which have been overwhelmingly positive.

“PCNs are still the greatest change to the NHS that nobody outside of primary care has ever heard of.”

Clinical Director

In part, this will involve ensuring that there is public awareness of what exactly PCNs do.

More broadly, we must begin to promote links with local authorities. For PCNs to best assess and deliver according to local need, clinical directors could be building links with ward councillors to develop a shared understanding of the health profile of their residents. The government and NHSEI should consider how they can encourage and facilitate this.

Key asks

Influence and autonomy

There is a clear desire among PCNs to have a voice at national level in determining their own future, and to have a central role in 'reset' locally as services begin to look beyond the COVID-19 emergency response phase.

We therefore ask NHS England and NHS Improvement and government to consider the following:

- The NHS Long Term Plan commits to ICSs having partnership boards that include PCN representatives. This should be reinforced and ultimately ensured through forthcoming policy and, if necessary, legislation.
- Opportunities should be created for policymakers to hear directly from clinical directors about their experience in leading PCNs. A more discursive form of policy development at national level will likely both improve evidence-based decision making and ensure that clinical directors feel they are helping to drive change.

One size does not fit all

It remains to be seen if and how the DES is to be revised as a result of COVID-19. Some clinical directors have urged a rethink of the specifications, with a sense that a 'one size fits all' approach will not be effective considering the huge variation in demography across networks. Equally, there needs to be flexibility for clinical directors to manage all aspects of their network in the way they see fit.

We therefore ask NHS England and NHS Improvement and government to consider the following:

- Leniency should be applied when assessing PCNs against the first year of the DES service specifications. Though these are not to be implemented until October, fatigue is currently (and will continue

to be) a problem for PCNs and their staff across the country. It is inevitable, therefore, that this will affect their ability to deliver against the specifications and CCGs must be encouraged to consider this as part of their assessment.

- Despite revisions in recent months, the ARRS remains restrictive for PCNs. To address the significant wide range of challenges that different networks will face locally, this should be relaxed as far as possible. PCNs should be able to use funding to recruit whichever roles they feel would be most appropriate to meet the needs of their local population.

Promoting integration in all areas

We are still in the infancy of the health and care integration outlined in the NHS Long Term Plan. To accelerate and embed integration, both in terms of culture and formalised structure, there are further steps that should be taken at national level.

We therefore ask NHS England and NHS Improvement and government to consider the following:

- The shift towards integrated care must be accompanied by streamlined processes for clinical directors, including in areas such as finance, contracting, regulation and reporting. NHSEI should work with the clinical director community to assess how such areas can be made as straight forward and time efficient as possible.
- Despite the success of some ICSs, there is in most areas of the country yet to be a system-wide approach to population health management across all providers. If this is to be seen in future, it must be supported by a clear strategic commissioning approach and underpinned with focused funding in the right places. This is something that a forthcoming legislative framework must ensure.

Next steps

Through ongoing engagement with networks, specifically including clinical directors and network managers, we look forward to supporting both NHSEI and the government in delivering the asks detailed in the previous section. We intend to work collaboratively with both to ensure that the PCN voice is heard and that their role in systems is clear and widely understood over the coming years.



How to stay in touch

We offer a wide range of email newsletters, including:

- PCN Clinical Directors' Update
- Regional integrated care bulletin
- Media summaries
- Member Update
- NHS European Office Update
- Mental Health Network Update
- NHS Clinical Commissioners Update
- NHS Brexit Bulletin
- BME Leadership Network Bulletin
- Health and Care Women Leaders Bulletin
- NHS Confederation chief executive's blog

Visit us at www.nhsconfed.org/PCN-Network

Blog with us on NHS Voices – visit www.nhsconfed.org/blog

Showcase a case study of innovative work – visit www.nhsconfed.org/resources



18 Smith Square, Westminster, London SW1P 3HZ

Tel 020 7799 6666

Email enquiries@nhsconfed.org

www.nhsconfed.org

Follow the NHS Confederation on [Twitter](https://twitter.com/nhsconfed) @nhsconfed

If you require this publication in an alternative format, please email enquiries@nhsconfed.org

© NHS Confederation 2020. You may copy or distribute this work, but you must give the author credit, you may not use it for commercial purposes, and you may not alter, transform or build upon this work. Registered Charity no. 1090329