



PCN  
Network  
NHS Confederation

# Primary care networks

Two years on

August 2021

Julia Swift

# About

This report considers the progress of primary care networks two years on from their creation, exploring the challenges they have faced and the opportunities that lie ahead with the move to greater system working.

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

The PCN Network, which is part of the NHS Confederation, is the membership body for primary care networks, supporting their development and ensuring they are effectively represented within the health and care system.

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# Foreword

The health and care system is being transformed and primary care networks (PCNs) are underpinning this transformation. They are both the source of population health intelligence and the key to moving services out of hospitals, creating a multi-disciplinary workforce and focusing on preventative care.

These are, of course, lofty ambitions. Yet throughout the engagement process for this report, it was clear that PCNs are rising to the challenge, making progress both in spite and because of the demands of the pandemic. We have heard from PCNs that have galvanised their communities to administer vaccinations, pressing ahead in the face of enormous workload pressures to build local relationships and develop their workforce. This report provides a snapshot of this enthusiasm, alongside themes relating to challenges and successes that we hope provide useful intelligence to inform the development of PCNs within integrated care systems (ICSs).

As we transition to statutory ICSs, it is vital that this enthusiasm and commitment for PCNs remains intact. Managing population health is central to the new health and care system, with PCNs being its natural advocates and providers, forging links with their communities and delivering tailored care. ICSs must make the most of this, understanding what PCNs do and can do in the future, as well as ensuring their voice is both heard and influential.

This will require working as a partnership of equals, understanding how system partners can work as one to manage population health and rise to the challenges arising from the pandemic. PCNs have a clear role to play in out-of-hospital care and, with an extended workforce of health professionals within the community, have much to add to the implementation of a system-wide, strategic approach to waiting-list management.

We are grateful to all the PCNs that took part in the research for this report – your input has been invaluable. If you would like to find out more about the PCN Network, please do get in touch.

**Ruth Rankine**  
**Director**  
**PCN Network**

**Dr Pramit Patel**  
**Chair**  
**PCN Network**

**Dr Graham Jackson**  
**Senior Clinical Adviser**  
**NHS Confederation**

# Key points

- Despite still being in their infancy, primary care networks (PCN) have played a leading role in England's response to COVID-19. Just two years on from their creation, they have risen to the challenges presented by the pandemic, administering the majority of vaccinations, reaching out to underserved communities and making headway against their objective to tackle health inequalities.
- As they approach the mid-point of their five-year contract, this report considers their progress and successes so far, the challenges they have faced and the opportunities that lie ahead with the move to greater system working. It is based on a series of engagement sessions, hosted by the PCN Network, and a survey of more than 150 PCN clinical directors and PCN managers. The report also sets out principles to guide the development of PCNs and key areas for improvement within the network contract direct enhance service (DES).
- Overall, the picture is one of progress, with high levels of enthusiasm for PCNs remaining despite the challenges posed by a high workload and reacting to COVID-19. PCNs' profile has increased, leading to greater awareness of the services they offer; relationships with local partners have been strengthened; workforce development has been evident in increased numbers, leadership capability and retention; and PCNs are developing creative ways to reach underserved communities, tackle health inequalities and manage population health.

- Challenges remain. More than nine in ten survey respondents said their workload was greater than expected, with the consistently high workload derailing PCNs' existing and planned work programmes. New service specifications are causing confusion over the purpose of PCNs, while a lack of consistent infrastructure was seen as hindering progress. Tensions were also identified with some local partners.
- Our one year on report, released in July 2020, identified three principles for NHS England and NHS Improvement to consider when developing PCN policy, accompanied by a set of asks. They centred on PCNs having autonomy over their resources and influence over policies determining their future, as well as within ICSs; a flexible approach to be factored into their development; and for the shift towards ICSs to be accompanied by streamlined processes for PCNs.
- These principles have informed PCN policy over the past year, especially with regards to the health and care bill and ICS guidance. While the 2021/22 network contract DES addressed some of the asks, they have not been resolved fully and remain relevant. We encourage NHSEI to use these principles to underpin the development of PCN policy and all policies that impact PCNs.
- Through continuing engagement with clinical directors and PCN managers, we will develop specific asks for the 2022/23 network contract DES in the autumn, relating to workload management; funding for PCN leadership and management; certainty around funding streams and contractual arrangements; and consistent and streamlined processes.

# Background

July 2021 marked the two-year anniversary of PCNs. PCNs were introduced with the stated aims of stabilising general practice, dissolving the historic divide between primary and community health services, and reducing health inequalities. The pandemic has, of course, derailed PCN development. Yet progress has been made in spite of this, with many clinical directors citing the vaccination programme as a catalyst for collaboration within and across PCNs.

The transition to ICSs places population health management centre stage. PCNs' proximity to patients and aim of tackling health inequalities renders them indispensable to the success of ICSs. Looking ahead, ICS priorities must reflect total population need, yet they will also need to take heed of population diversity at a local level and PCN engagement will be a deciding factor in this. Establishing place-based partnerships and provider collaboratives that both include and are informed by PCNs will be instrumental in achieving this, enhancing local population health management and creating a much-needed golden thread between neighbourhood and system levels to ensure ICS objectives are evidence-based.

The PCN Network has therefore sought to understand the progress of PCNs as they approach the mid-point of their five-year contract, discerning the successes so far and the challenges they have faced along the way. To do so, we hosted a series of engagement sessions with clinical directors and PCN managers. This was followed by a nationwide survey asking them to indicate their

extent of agreement with the issues raised during the engagement sessions. Overall, we had 157 survey responses, including 88 clinical directors and 49 PCN managers, as well as 73 attendees at the engagement sessions.

Through this engagement, we heard about the high levels of enthusiasm that remain for PCNs despite the challenges posed by a high workload and reacting to COVID-19.

This report sets out the key themes from this engagement, alongside a look ahead to the future of PCNs. It sets out principles to guide the development of PCNs and key areas for improvement within the network contract DES, followed by opportunities for PCNs in ICSs.

“One of the biggest achievements has been the camaraderie of the vaccination programme.”

**Clinical Director**

# What has gone well?

## Relationships with local partners

Building on improvements made in the first 12 months, relationships with local partners are much stronger than before the introduction of PCNs. Crucially, these relationships are now translating into cooperation, joint working and being commissioned by local authorities to provide services that primary care has not traditionally provided.

Although some of the development of PCNs has been interrupted by the pandemic, clinical directors and additional roles reimbursement scheme (ARRS) staff have now had time to settle into their roles. This has allowed them to better understand the stakeholder landscape, make contact with them and develop relationships.

Member practices, neighbouring PCNs, GP federations, local authorities, the voluntary sector and other parts of the health system have united around the shared purpose of delivering the vaccination programme. There are examples of PCNs working with GP federations, other PCNs, and other primary care providers to deliver the programme at scale within their locality. There are also examples of CCGs providing additional support and of PCNs working with public health teams at local authorities to reach underserved patients, as well as other departments to secure vaccination sites.

“ Our local authority public health lead applied to the government and got the grant for the Tier 2 weight management post-covid, and the first people she contacted were the PCN clinical directors to work out how we were going to spend that money.”

**Clinical Director**

66%

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of respondents agree local relationships  
have improved

### **Case study: Scaling a PCN and voluntary sector partnership to improve children and young people's mental health**

The member practice surgeries of Outer West Newcastle PCN were experiencing high levels of young people presenting with anxiety, low mood, poor self-esteem, bullying and poor attendance, often being sent to see their GP by their school.

After contending with long waiting lists or non-acceptance of referrals for children and young people's services, the PCN contacted Streetwise, a local voluntary sector organisation, to work together on a service for 11-18 year-olds experiencing low level mental health problems.

Initially, the service was commissioned as one whole-time equivalent (WTE) but was increased to two WTE due to high demand. The staff are employed as health and wellbeing coaches via the additional role reimbursement scheme. They work in the school the majority of the time, but they are also accessible via each PCN surgery and a local community centre.

The PCN has a patient list of 54,000 and in the first three months, 55 children and young people used the service, with ten being referred into the single point of access at the children and young people's services, although the health and wellbeing coaches continued to offer support while they waited to be picked up by this service.

This model is now been replicated by two other PCNs, with the Streetwise/PCN service being rolled out in another school in the area.

## Profile

For those PCNs at the head of the curve, their profile with the public and the communities they serve has improved over the last 12 months. In many areas, patients and communities better recognise PCNs as part of the healthcare system, leading to an increased understanding of the services they offer.

This is mainly attributable to the vaccination programme. With the majority of vaccinations having been administered by PCNs, particularly during the earliest stages of the programme, alongside the assembly of local vaccination sites, the high-touch approach to booking patients for vaccination, and media coverage, PCNs' public profile has increased.

For PCNs, the benefits of this include a larger platform to promote their services and healthcare messages, as well as being contacted to run projects.

“ We have really started to build relationships with communities.”

**PCN Manager**

## Workforce development

Positive developments have taken place within PCNs' workforce. Further progress has been made in recruiting professionals into extended roles via the ARRS and as standalone PCN managers; PCN and member practice staff cohesion has increased; and professionals from general practitioner and other clinical backgrounds are in leadership roles.

These developments are underpinned by ARRS staff and clinical directors being better embedded in their roles, as well as virtual, non-clinical working, which have all aided cross-practice communication and the development of multi-disciplinary teams. Many clinical directors and PCN managers have also noted that attitudes are shifting towards primary care being viewed as more than general practice. PCNs have also been able to take advantage of training opportunities through training hubs and links with higher education institutions to develop their workforce.

For many member practices this is translating into practical benefits, including a more appropriate workload for GPs, better outcomes for patients, as well as GP retention. However, this is not a uniform picture. Differences in accessing training as well as ARRS recruitment and supervision issues have affected workforce development. Furthermore, PCNs that have recruited PCN managers noted their positive effect on both workforce development and PCN cohesion.

“ It’s not just about doctors, which is brilliant.”

**Clinical Director**

“ Sharing staff and learning across practices has been invaluable.”

**PCN Manager**

62%

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of respondents agree that PCNs have developed into strong learning environments

## Spotlight: Reflections from a nurse clinical director

After 18 years as a nursing officer, I left the Army in 2017. My first 'civilian' role was within a vanguard programme, working to integrate acute and primary care by supporting people with complex health needs. I was employed by an at-scale primary care provider, working across – and very closely with – 19 practices in South Somerset, mainly in Yeovil.

In May 2019, I was approached by the practices in Yeovil and asked to become the clinical director for the then-forming Yeovil PCN. I continued to lead in complex care, becoming associate director for community transformation at Yeovil District Hospital. Then, in 2021, I was seconded to work full time in primary care as the clinical director.

For me, being a clinical director is, firstly, about supporting practice sustainability through creating capacity. And, secondly, it's about ensuring equality of access for patients and workforce, the latter of which I do through creating opportunities for growth, networking and innovation.

I really enjoy spending time empowering people, both staff and the people we care for, so that they can thrive. It's all about connecting with people, joining-up conversations and ideas, and then turning them into wonderful outcomes.

Given my background, I bring a different perspective to our PCN board, which has kickstarted new ways of working, helping us to develop a population-based approach to patient care.

**Kat Dalby-Welsh, Nurse Clinical Director, Yeovil PCN;  
Vice-Chair, PCN Network Board**

## Population health management

The past 12 months have shone a light on health inequities, both through the uneven impact of the virus itself and the outstanding efforts made to vaccinate underserved patients.

Historically, much of primary care has been reactionary and dependent on patients presenting within surgeries. Now, after two years of PCNs, networks are making headway on delivering PCNs' population health management objectives. Spurred on by COVID-19 and the vaccination programme, there are examples of PCNs regularly meeting with their public health counterparts, the voluntary sector and community groups to better understand their populations. This has led to increased awareness of health inequalities and underserved populations from which PCNs have been able to develop projects to address. It has also resulted in a focus on prevention, with creative joint projects such as allotments being developed with neighbourhood-level partners. Importantly, many PCNs are taking ownership of this agenda, moving from reacting to individual patient need to understanding population needs and taking a proactive approach to meeting them.

However, once more, progress in this area varies and is heavily dependent on workforce capacity and local relationships; practice engagement; PCN management capability; CCG and system support for data and analytics, as well as links with local authorities. PCNs have been able to make real progress in many areas across the country, but we fully recognise the variability in maturity of PCNs based on a multitude of factors

“ We've really taken that health inequalities agenda and we're owning it.”

**PCN Manager**

### **Case study: Forging links with the Pakistani and Bangladeshi communities to deliver tailored care**

As part of the vaccination programme, Wokingham North PCN has been working with the local authority to analyse data and identify underserved communities. This led to outreach work to encourage vaccine uptake among the area's Pakistani and Bangladeshi communities.

Consequently, the PCN has been able to forge links with the local mosque and has put in place a set of projects based around health and wellbeing. So far, this includes a webinar on staying healthy during Ramadan, as well as events focused on health and wellbeing and managing blood pressure, which ran concurrently with vaccination pop-up clinics.

Through conversations with the community, the PCN was able to tailor the content of these projects to community requirements, identifying issues surrounding health and wellbeing, especially in light of COVID-19 bereavements.

## 74%

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of respondents agree that the vaccination programme placed a strong focus on population health and health inequalities

# Challenges

## Workload

Similarly to the progress at 12 months, workload remains a challenge for all PCNs. For many clinical directors this is resulting in fatigue, burnout and insufficient time for PCN development as they grapple with balancing the strategic and operational demands of the PCN alongside their clinical commitments.

Over the past 12 months, PCNs have contended with network contract DES and COVID-19 vaccination service specifications; the transition to ICSs; PCN management activities and core practice clinical activities, including their own and secondary care's elective backlog as a result of the pandemic; alongside increased clinical demand as lockdown restrictions are lifted. This has resulted in capacity issues both within PCNs and across the whole of primary care.

The symbiotic relationship between PCNs and general practice means it is difficult to separate the two workloads. Aside from ARRS staff and PCN managers where they exist, the workforce is the same. Furthermore, patients access both general practice and PCN services in the same way while most patients are referred to ARRS staff by a GP. In practice, this means PCN staff and services cause little reduction in GP workload in the first instance.

In addition to clinical workload, bureaucracy and administration place a heavy burden on clinical directors, with many noting the

sheer volume of information returns required for the vaccination programme, as well as the administrative workload related to running a PCN, such as supervising ARRS staff. Furthermore, many clinical directors are taking an active role in organising primary care leadership in preparation for ICSs.

“ The workload and burnout in primary care is, in my opinion, going to hinder the progression of PCNs.”

**Clinical Director**

“ When I talk about ARRS roles, people just say ‘who is going to mentor them?’”

**Clinical Director**

96%

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agree the workload is greater than expected

## Purpose

Clinical directors are reporting a lack of clarity surrounding the purpose of their role, noting how the high and unplanned clinical workload affecting general practice coupled with the introduction of vaccination programme specifications for PCNs, means PCNs are more likely to lose sight of their founding objectives, especially given the lack of certainty for PCNs beyond 2024.

The stated aims of PCNs were to stabilise general practice, breakdown the divide between primary and community services,

and to reduce health inequalities. Although progress is starting to be made towards these, especially work to reduce health inequalities, the intended work of PCNs has been interrupted by the pandemic and vaccination programme, and clinical directors are unsure as to what the future holds for PCNs. This is compounded by the high volume of unclear communications, clinical directors straddling multiple functions, the fast-paced transition to ICSs and confusion over the role of PCNs in ICSs.

Day to day, this means some clinical directors are unable to articulate their PCN vision, develop operational plans and lead staff, with clinical directors noting that they would like further direction on how to make the most of their ARRS staff. Overall, they feel much of their role is reacting to prescriptive communications from the centre.

“ I’m doing lots of things already and I don’t know if it’s my job to be involved in more.”

**Clinical Director**

“ There is still a lack of clarity around what PCNs are there to do – are we here to support the Long Term Plan?”

**Clinical Director**

## Infrastructure

Many PCNs report a lack of infrastructure as a limiting factor in their development. This includes estates and IT, as well as data and business intelligence.

PCNs are embryonic organisations and there is no provision for PCN-specific infrastructure, which results in a lack of uniformity across PCNs. Although the ARRS has increased the primary care workforce, there has been little recognition of how this has increased out-of-hospital care capacity and no corresponding commitment for estates infrastructure to support these staff, meaning their consultations must take place within member practices' existing estates. Similarly for IT, specific provision for ARRS staff has not been made, leaving them reliant on member practices' existing budgets. Estates is a particularly pressing issue, especially as more face-to-face appointments take place and ARRS staff such as podiatrists and first contact physiotherapists require consulting rooms.

Furthermore, many clinical directors point towards inadequate data, analytics and business intelligence as hindering progress in population health management. However, in some systems, these have been provided and progress has been made. Once more, this points to the lack of uniformity in infrastructure provision, which poses a serious risk to PCNs' development.

Clinical directors are therefore concerned about how to accommodate their workforce, especially where staff work across multiple practices, while some practices have no access to funding for PCN IT or data and business intelligence. This means there is wide variation in the infrastructure available to PCNs, affecting their ability to host their workforce and manage their population's health. As ICSs develop, they must recognise the importance of infrastructure for PCNs, developing strategic plans for improvement and making the necessary investments in estates, IT, data gathering, data analytics and business intelligence.

“Estates will be my limitation in using my ARRS budget.”

**Clinical Director**

“ We’re kind of working blind. There is so little business intelligence to support primary care that it’s ridiculous.”

**Clinical Director**

93%

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agree a lack of infrastructure to support PCNs is hindering their progress

98%

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agree additional funding for primary care estates is required

## Spotlight: IT issues

We have heard from PCN managers about the difficulties they have experienced funding IT for PCN-specific roles and activities. This includes laptops and VPNs, business intelligence tools, and the on-costs for mobile phones.

Where PCNs have managed to source IT equipment, it has been through member practices or GP federations. One PCN has laptops provided by member practices and via their federation, using the PCN development fund. This has led to issues with administration rights as the CCG-provided laptops are specific to a single practice, while the federation-provided laptops can only be used by a single member of staff employed via the federation. The same PCN has also experienced issues with the withdrawal of funding for analytics tools after the CCG ended a pilot scheme, and uncertainty over the CCG's future funding of VPNs.

The PCN has explored using the PCN development fund to cover these costs, but they are unclear how much they will receive. Ultimately, this makes it difficult for PCNs to purchase the equipment they need, as a PCN manager stated: "In a nutshell, PCNs don't have an IT budget and development funding won't cover all of our needs."

## Relationships with NHS partners

Although local relationships are improving in many respects, some relationships within the NHS have been challenging.

These tensions may be attributable to the management and recovery of COVID-19, particularly the elective care backlog and the vaccination programme; the drive to integrate care via the ARRS; the transition to ICSs; and a sense that some NHS stakeholders do not view PCNs as equal partners, although this is improving.

The pandemic has placed enormous strain on all parts of the NHS, resulting in backlogs that can only be cleared through system working. However, PCN leaders perceive that other parts of the NHS believe their focus on the vaccination programme has been to the detriment of general practice core activity. Of course, this is not the case. With PCNs' workforce being indistinct from that of general practice, any increase in workload for one also increases workload for the other. In addition to the vaccination programme, general practice has been contending with increased clinical demand as a result of patients returning to their GP post-lockdown and simultaneously managing secondary care's backlog.

As with PCN challenges at 12 months, issues with CCGs and other NHS providers persist. There are many examples of strong and appropriate support from CCGs, and PCN maturity has progressed well in these areas. However, there is inconsistency in approach from the commissioner to infrastructure. Some clinical directors have also reported not receiving payments for the vaccination programme and a standard of service that was below expectations.

Although the transition to ICSs may go some way to alleviating these issues, many PCNs do not think they are treated as an equal partner and report fears of being the ICS 'dumping ground'. The impact of this may be detrimental to ICSs delivering on their objectives.

“ We quite clearly have a mental health trust who is solving their issue with CQC by trying to give PCNs their waiting list.”

**Clinical Director**

“Any plans that involve secondary care always stall.”

**Survey respondent**

# Looking to the future of PCNs

Overall, COVID-19 and the vaccination programme have both interrupted and altered the development of PCNs. Nevertheless, many PCNs have made headway in their own development as nascent organisations and on delivering PCN objectives, which is testament to the enthusiasm and commitment for PCNs among primary care.

Although PCN development is varied, the vaccination programme has been a catalyst for collaboration. PCNs have delivered the majority of vaccinations in one of the world's most successful vaccination programmes, resulting in a real sense of pride and camaraderie. Furthermore, where local systems and environments have been supportive, PCNs have – and would have – made progress despite the vaccination programme.

For the most part, the challenges PCNs face are practical and can therefore be easily rectified. Where they are not, namely local NHS relationships and workload, they can be ascribed to the transition to ICSs and the necessities of COVID-19. Over time, we therefore expect these issues to subside as system working becomes embedded and the pandemic becomes more manageable.

Moving forward, the network contract DES must solve the practical issues PCNs face, while the vision for PCNs must be reiterated and organisational development support provided. This includes being underpinned by a set of objective and approach-based principles

to guide both immediate network contract DES design and long-term PCN development. Furthermore, guarantees regarding the future of PCNs beyond 2024 must be given as a matter of urgency. This would enable PCNs to take a long-term, strategic view, planning for their own organisational development and for their populations' health needs.

“ One of the biggest challenges is seeing what the PCN is beyond the initial five years DES period and what it will evolve towards.”

**PCN Manager**

There is a risk that, should they merely play lip service to system working, the transition to statutory ICSs may not resolve the issues surrounding workload and relationships. Unfortunately, primary care is already raising concerns regarding working with secondary care to clear the elective backlog, which has resulted in an increased primary care workload in some areas with no access to the elective care recovery fund.

PCNs are the building blocks of ICSs and primary care's voice must be valued as the conduit for population health, enabling system priorities to reflect local population needs. Given the issues PCNs have faced with regards to NHS partners, this will require a culture change from ICS leaders and secondary care.

“ Cooperation from secondary care has been appalling, with them only providing lip service from their high-walled bunker.”

**Survey respondent**

# Principles to guide the development of PCNs

In our 2020 report, [Primary Care Networks: One Year On](#), we identified three principles to consider when developing PCN policy, accompanied by corresponding asks. These principles are set out below and have been updated to reflect developments over the past 12 months.

It is clear that these principles have informed PCN policy over the past year, especially with regards to the health and care bill and ICS guidance. Furthermore, many of these asks have been addressed through the 2021/22 network contract DES, yet they haven't been resolved across the board. The principles therefore remain relevant, and we would like to see them underpin the development of PCN policy, as well as policies that impact PCNs, moving forward.

We shall be developing specific asks for the 2022/23 network contract DES in the autumn, relating to:

- workload management, including flexibility surrounding service specifications
- funding for PCN leadership and management
- certainty regarding funding streams and contractual arrangements
- consistent and streamlined processes.

87%

think no service specifications  
should be introduced in 2021/22

## Influence and autonomy

It is clear that PCNs wish to have a voice in determining their future at national level, as well as in the strategy, operation and clinical leadership of ICSs. Furthermore, many PCNs would like more autonomy, enabling them to better plan and develop strategies for their population needs. Naturally, this increased autonomy must be accompanied by appropriate in-system checks and balances, alongside oversight mechanisms.

Further opportunities for policymakers to hear directly from PCNs should be established to improve evidence-based decision-making and ensure that clinical directors influence policy development. Additionally, the important role of PCNs in ICSs should be made explicit in ICS guidance to ensure that system priorities reflect local population needs. This should include emphasising the importance of PCNs in place-based partnerships and provider collaboratives. Finally, in-year payments and assurances over the future of PCNs beyond 2024 must be given. This would enable PCNs to plan for the long term, reducing the derailing effect of service specifications on PCNs' organisational strategies.

“ The more freedom they can give us, the better.”

**Clinical Director**

## One size does not fit all

PCN development has not been uniform, with a wide variation in factors that have influenced progress, including existing relationships and the pandemic response. As the health system recovers from the effects of COVID-19 and transitions to statutory ICSs, the diversity of PCNs must be factored into their assessment. Moreover, a flexible approach to ARRS and service specifications should be adopted to take account of the effects of the pandemic and the local challenges PCNs face.

“ One size does not fit all. Rural PCNs are at a significant disadvantage when it comes to working to scale and sharing staff.”

**Survey respondent**

## Promoting integration in all areas

Both the introduction of the health and care bill and the ICS Design Framework go some way to promoting integration. However, integration requires strong system partnerships and the extent to which these partnerships are recognised, created, managed and maintained will rely on the detail of each ICS constitution, while PCN participation in provider collaboratives remains unclear.

“The payment processes for PCNs are bureaucratic and hampering development.”

**Clinical Director**

Finance, contracting, regulation and reporting processes must therefore be streamlined, with variations in the approach of

CCGs eliminated with the transition to ICSs. Following this, ICSs must develop a system-wide approach to population health management with a clear, PCN-informed approach to commissioning and focused funding. Moving forward, PCNs and other system players must be represented in ICS discussions on funding and collaborative contracting, with mechanisms developed to ensure their input and views are properly considered.

# Opportunities for PCNs in ICSs

In our report, [The Role of Primary Care in Integrated Care Systems](#), we set out five key requirements for primary care to engage effectively in system working:

- Collective voice and representation for primary care at system level.
- Processes and structures for primary care at place.
- System priorities that reflect local neighbourhood needs.
- Systems that promote collaboration.
- Enablers, including investment in primary care leadership capacity and capability, and financial certainty.

These requirements relate to the mechanics of ICSs and, if realised, will provide opportunities for PCNs in ICSs, including the three identified below.

## Making best use of technology

COVID-19 has accelerated the use of technology in PCNs and wider primary care. This is a broadly positive development and it is clear that there are further opportunities to embed technology not only across PCNs and primary care, but across ICSs to promote system working.

These could include managing patient demand, integrating workforce, and providing patient-centred care. The success of population health management also depends on making best use of technology, not only in gathering, accessing and analysing data, but also in ensuring this analysis informs ICS strategy.

However, this means a similar adoption of technology across the system as has happened in primary care, and for care to be designed around the patient. It also means that all system partners must prioritise population health management, ensuring decisions are informed by data and analysis at neighbourhood level. It also requires an assurance that technology will be used only where it results in enhanced patient and staff outcomes.

**We therefore ask NHS England and NHS Improvement and government to consider:**

- placing responsibilities on each ICS to develop a system-wide, strategic plan for infrastructure provision and usage, including IT
- placing responsibilities on each ICS to develop a system-wide, strategic plan for data, analytics and business intelligence provision and usage.

## 64%

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of clinical directors and PCN managers agree there are significant opportunities to expand the use of digital channels

## PCNs as lead partner

As system partnerships develop, PCNs could play a leading role in decisions regarding neighbourhood-level and at-place service provision, particularly for out-of-hospital care. This includes deciding services and workforce requirements for each PCN based on its population need, as well as being lead partners at place level. This would ensure PCNs' services and workforce are reflective of local population health needs and that place-level services are informed at neighbourhood level while also fostering a focus on preventative care and enabling more services to take place outside of hospitals.

To enable this, PCNs must be equipped with the data and resources to undertake community engagement while ICS constitutions must ensure appropriate mechanisms for delegation of responsibilities and budgets to place-based partnerships. However, there is a risk that this could lead to different service provision at neighbourhood level. Remedying this would require further allowance for the delivery of primary services at scale beyond the PCN level.

**We therefore ask NHS England and NHS Improvement and government to consider:**

- mandating the inclusion of PCNs in place-based partnerships
- clarifying the processes and mechanisms for delegating budgets and responsibilities to place-based partnerships.

“ Give PCNs the freedom to use resources to deliver on local priorities.”

**Clinical Director**

## Primary care at scale

PCNs are proof of concept for primary care at scale. As ICSs mature, there could be opportunities for primary care to be scaled to a ‘network of network’ level or beyond, such as for digitally-accessed services that are not geographically bound.

In some cases, this already exists in the form of GP federations, the network collaborations that have developed to administer the vaccination programme, and existing digital services. These demonstrate the benefits of primary care at scale, including efficiency and cost-effectiveness, increased availability of services for patients, and out-of-hospital service provision.

For primary care at scale to develop further, it must move away from being reliant on informal relationships within primary care. Instead, it should be made explicit that primary care providers are able to form provider collaboratives.

**We therefore ask NHS England and NHS Improvement and government to consider:**

- clarifying the role of primary care in provider collaboratives.

“ There are opportunities to work at scale, providing services that would otherwise be provided by secondary care.”

**Survey respondent**

# Next steps

Through ongoing engagement with members, we will provide reflections on if or how any publication of further service specifications in 2020/21 affects the content of this report. Consequently, we will be publishing specific asks in relation to the 2021/22 network contract DES in the autumn.

We look forward to working with NHS England and NHS Improvement and the government on the development of PCNs, helping to ensure the requirements laid out in [The Role of Primary Care in Integrated Care Systems](#) and the asks set out in this report are realised. We intend to work collaboratively with both over the coming years to ensure the PCN voice is heard, and that their role in systems is clear and widely understood.

18 Smith Square  
Westminster  
London SW1P 3HZ

020 7799 6666  
[www.nhsconfed.org](http://www.nhsconfed.org)  
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