5 September 2019	ITEM: 9
Health and Wellbeing Overview and Scrutiny Committee	
Primary Care Networks (PCNs)	
Wards and communities affected: All	**Key Decision:** Not applicable
Report of: Rahul Chaudhari, Director of Primary Care, Clinical Commissioning Group	
Accountable Assistant Director: Not applicable	
Accountable Director: Mandy Ansell, Accountable Officer, Clinical Commissioning Group	
This report is public	

Executive Summary

This paper provides the members with an update on the Primary Care Networks and how it impacts Thurrock.

The update includes how the networks will help address workforce shortages in general practices and focus on improving primary and community services, getting people to be healthy, proposals on the range of clinical priorities.

Members will be provided with details on the number of Primary Care Networks in Thurrock and their named Accountable Clinical Directors. The additional roles under the Primary Care Networks and the financial entitlements will be explained including how these will support in achieving the anticipated outcomes and how designated funding will be allocated to support the employment of additional staff.

Members will be advised on key national requirements expected off the PCNs in 2019/20 and how each of our networks performs against these requirements. The paper also provides information on the help and support that would be offered to the networks both nationally and locally.

1. Recommendation

Health and Wellbeing Overview and Scrutiny Committee members are asked to note the update.

2. Introduction

Following discussions in January 2019 between NHS England (NHSE) and the British Medical Association (BMA) General Practitioners Committee about

reforming the general practice contract, a five-year contract framework was agreed to support the deliverable aims of the NHS Long Term Plan. The introduction of the new Network Contract Directed Enhanced Service (DES) is to focus on a new way of working enabling health and other services to work together to provide better access for patients – under the umbrella of an Integrated Care System (ICS).

ICSs in some larger areas are led by groups of NHS and local government leaders and are based on voluntary collaboration. Their principal functions are planning for the future, building on the work that went into Sustainability and Transformation Partnerships (STP); aligning commissioning behind their plans, incorporating the regulatory functions of NHSE and NHS Improvement (NHSI), managing performance in their areas and providing leadership across the system covered by the ICS. Responsibility for service delivery rests with the organisations that provide care within ICSs and many of these organisations are collaborating to put in place Integrated Care Partnerships (ICP).

Resources for primary medical and community services increase by over £4.5 billion by 2023/24, and rise as a share of the overall NHS national budget with £1.799 billion made available to GP practices in PCNs via the Network Contract DES by 2023/24.

The Network Contract DES will support practice/partnership to achieve collaborative working under the creation of Primary Care Networks (PCN); and the Network Agreement will set out how they will do this. By 2023/24, with £1.47 million investment per typical PCN covering 50,000 patients, this includes recurrent £1.50 per patient and guaranteed funding to recruit healthcare professionals such as Clinical Pharmacists and social prescribers in 2019/2020, and from 2020/21 Physiotherapists and Physician Associates; then from 2021/22 paramedics – increasing workforce to 20,000 plus. The funding for these additional roles will be based on capitation as opposed to allocation from 2020/21. Apart from the social prescriber, PCNs will be reimbursed at 70% for all the other roles.

It is believed by creating these additional healthcare professionals, working alongside their GP colleagues, as part of the multi-disciplinary team will take the pressure off GPs. A brief overview of each role is listed below.

Clinical Pharmacists: working as part of the general practice team, they are highly qualified experts in medicines and can help people in a range of ways e.g. carrying out structured medication reviews for patients with ongoing health problems and improving patient safety, outcomes and value through a person-centred approach.

Social Prescriber: helps patients to improve their health, wellbeing and social welfare by connecting them to community services which might be run by the council or a local charity e.g. signposting people who have been diagnosed with dementia to local dementia support groups.

Physiotherapists: help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice. They maintain health for people of all ages, helping patients to manage pain and prevent disease.

Physician Associates: can diagnose and make referrals; and provide patients, especially those with long-term conditions, the continuity of care they need.

Paramedics: can be the first point of contact for the house bound patient; help people manage people in their own homes through home visits and wellbeing home visits and prevent disease and illness through immunizations/ vaccinations and screenings. They can provide information about ways to care for themselves and their families.

The aim of the PCN is to build on the core current primary care services and enable greater provision of integrated health and social care. Network memberships are formed by local agreement and consist of groups of general practices working together with a range of local providers across primary care including community pharmacy, optometrists, dental providers, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care. Each PCN will have an appointed named accountable Clinical Director (CD) typically serving their local population of at least 30,000 up to around 50,000 within the boundaries of its member practices. PCN Clinical Directors will provide leadership for PCN's strategic plans through working with member practices and the wider PCN to improve the quality and effectiveness of network services. Together, CDs will represent their PCNs and will play a critical role in shaping and supporting their ICSs.

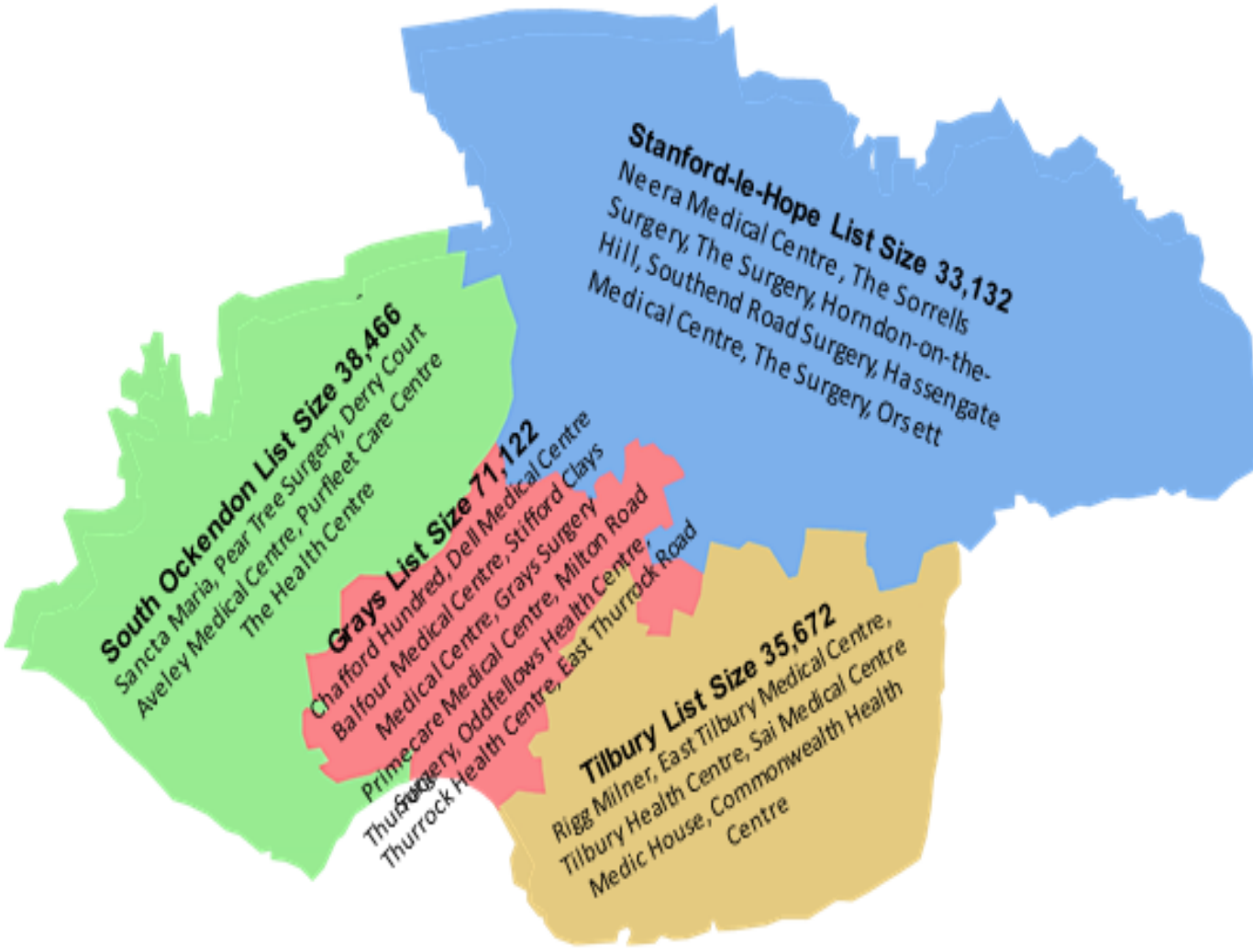
The aim is to have PCNs that are small enough to maintain the traditional strengths of general practice, but at the same time large enough to provide resilience and support the development of the integrated teams.

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

PCNs had to submit their registration to their respective Clinical Commissioning Group (CCG) for approval by 15 May 2019 with 100% network contract go-live from 1 July 2019. Whilst it is not mandatory for a practice to join a network, said practice will lose out of significant funding to neighbouring practices that provide primary care services to said patients. One of the key requirements for PCNs was member practices needed to be geographically aligned with a named single practice or a provider that will receive funds on behalf of the PCN.

Thurrock CCG has given the approval of four PCNs covering the practices' localities within its area. These are:

- Stanford-le-Hope & Corringham
- Tilbury & Chadwell
- Grays
- Aveley, South Ockendon and Purfleet (ASOP)



Thurrock CCG has always been working with practices on a locality foot print and one of our successful case study has been the Tilbury and Chadwell model which not only helped inform the Mid and South Essex STP primary care strategy but also attracted additional funds from NHS England's national team to roll out the model in our Grays locality. The developed model was evidenced-based estimating the likely case mix of attendances in primary care and then securing an estimation of alternative staff needed to deliver against that need.

The above model aims to free up GP time and allows them to concentrate on the most complex patients. There is an evidence base around the positive impact of this on demand on other parts of the system. For example, continuity of care relationship with a GP for patients with multi-morbidity has shown to reduce unplanned hospital admissions. Similarly a direct access to physiotherapy costs £56 vs circa £600 for a traditional model where a patient sees a GP first before being referred into the physio service, and showed better outcomes in patient care and satisfaction.

Although this model still needs evaluating for our local health economy initial responses have been positive and staff have seen an improvement in the care they are able to give to their patients.

A full list of the PCN practices and contact details, including branch sites, are provided in Appendix 1.

Stanford Le Hope & Corringham PCN

This PCN incorporates 6 practices and has a patient population of 32,551. The appointed Clinical Director is Dr Sharma, and the lead PCN practice is Hassengate Medical Centre. To date, the PCN has formed and the partnership has been approved by the CCG. The PCN has commenced reviewing its enhanced skill-mix of healthcare professionals which will be part funded by the PCN workforce funding.

Grays PCN

This PCN incorporates 10 practices and has a patient population of 71,122. The appointed Clinical Director is Dr Wendorff, and the lead PCN practice is Oddfellows Hall Health Centre. To date, the PCN has formed and the partnership has been approved by the CCG. The PCN has commenced reviewing its enhanced skill-mix of healthcare professionals which will be part funded by the PCN workforce funding.

Aveley, South Ockendon and Purfleet PCN

This PCN incorporates 6 practices and has a patient population of 38,466. The appointed Clinical Director is Dr Munshi and is based at the PCNs lead

practice of Purfleet Care Centre. To date, the PCN has formed and the partnership has been approved by the CCG.

Tilbury & Chadwell PCN

This PCN incorporates 6 practices and has a patient population of 35,537. The appointed Clinical Directors are Dr Chris Olukanni and Dr Reg Rehal and based at the PCNs lead practice of Commonwealth Health Centre. To date, the PCN has formed and the partnership has been approved by the CCG. The PCN has commenced reviewing its enhanced skill-mix of healthcare professionals which will be part funded by the PCN workforce funding.

Thurrock PCN profile against the requirements

In 2019/20 every PCN Needs to have signed network agreement DES, a named CD, 100% extended hours provision, social prescriber and a clinical pharmacist. The table below describes the PCN profiles against the requirements.

National PCN requirements for 19/20	Stanford le hope and Corringham	Tilbury and Chadwell	Grays	Aveley, south Ockendon and Purfleet
100% practices within a PCN	√	√	√	√
Signed Network DES agreement	√	√	√	√
A named clinical director	√	√	√	√
100% extended hours provision	√	√	√	√
1 social prescriber	√	√	√	√
1 clinical pharmacist	Will be going out for recruitment	√	√	Will be going out for recruitment

Two out of the 4 CCG's PCNs have been resourced with the additional skill mix staff in year 1 that is nationally promised over the next 3 years. The aim is to undertake an impact evaluation of this approach in 2019/20 to make a case for additional investment to resource the remaining 2 PCNs.

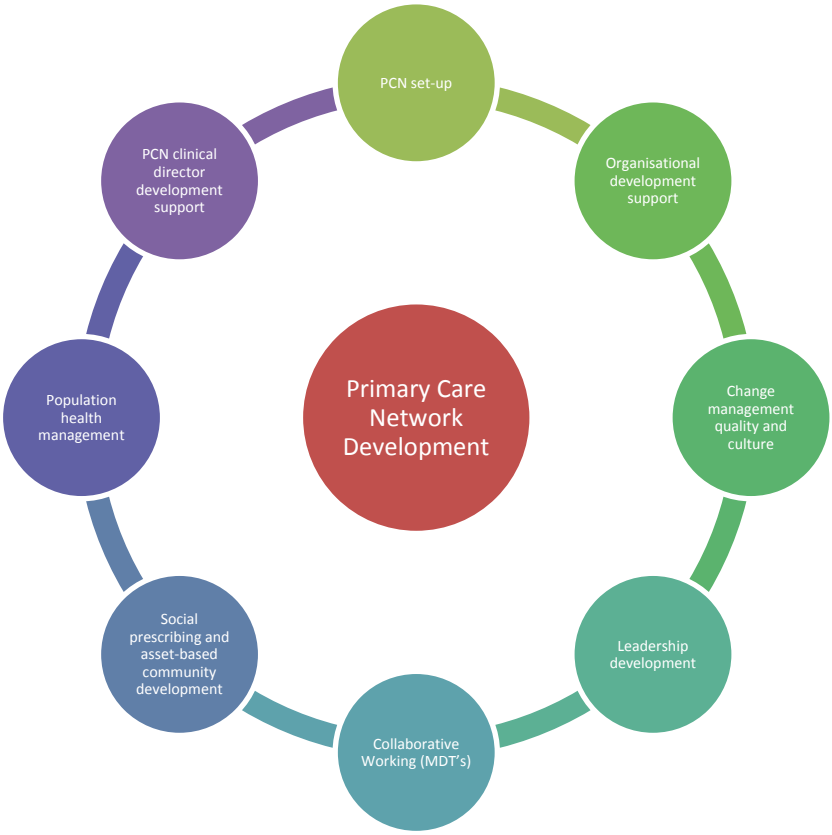
PCN 5 year long term plans

Every PCN will be expected to begin service delivery in an incremental way as they develop and mature. A nascent PCN will have to establish structure and governance arrangements before it can move towards setting up services and acquiring the necessary workforce. Funds will be allocated to the STP to be able to support their developments depending on where the various PCNs are in their maturity. A self-assessment maturity matrix has been developed

that defines the end state for the PCNs and allows them to assess where they are on that journey to be able to provide a bespoke support offer to every PCN.

The maturity assessment matrix will assess the PCNs against 6 key themes:

- Leadership, planning and partnerships
- Use of data and population health management
- Integrating care
- Managing resources
- Patient and public partnerships
- A summary of key requirements for PCNs set out in Investment and evolution (these will be expanded upon in future iterations of the matrix as the specifications are agreed and confirmed)



Over the course of this year all PCNs will be asked to complete a self-assessment to identify their state of readiness and will be offered start up support provided by the Time for Care team.

Nationally Primary Care Network Development support prospectus includes eight (domains) modules of support, including a specific specification for PCN clinical director development support.

From our assessment of Thurrock PCNs we understand all of them are at Foundation stage, where the practices are developing relationships with their member practices and neighbouring PCNs and putting together their structure and governances arrangements. The CCG will work with the STP and the Regional Office to identify priority areas that require early support and prioritise access to the nationally provided and supported services.

3. Summary

Recognising that the NHS is required by Parliament to keep within its spending limit, and that this is ever challenging, these developments are primarily about improving health and care and in doing so, seeking opportunities to deliver its financial objectives. Integrated care and population health should not be expected to save money but have the potential to enable resources to be used more effectively. Therefore, health and care systems need to work more collaboratively with PCNs in developing new ways of working that goes beyond organisational boundaries to address local challenges of inequalities and rising demand with constrained budgets; as well as working to sustain and transform healthcare in the 21st Century for the local population.

PCNs provide local clinical leaders more control over the use of the collective resources at their disposal, thereby enabling them to influence the local partners, stakeholders, STP, ICSs with flexibility to move money around into a more effective part of the systems in line with the population needs. Providers and commissioners are generally working together to establish ICAs/ICSs and PCNs have a key role in shaping the services delivered to their local population.

Report of:

Rahul Chaudhari

Director of Primary Care

NHS Thurrock CCG