Primary Care Networks
Controversy, Covid and collective working

Cogora

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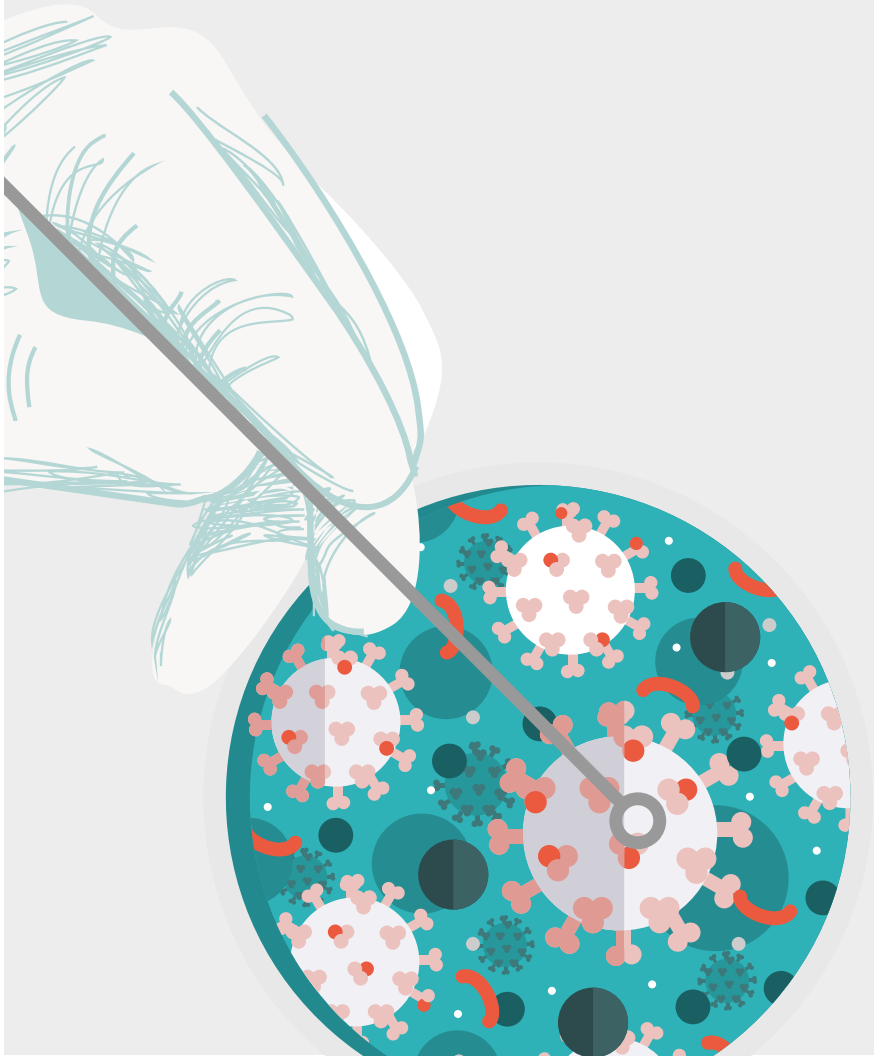

About this report

This temperature check on primary care networks (PCNs) after their first 16 months in operation and the impact of Covid-19 on their development is designed to help those in healthcare navigate this emerging market. It also highlights the opportunity for strategic partnerships with industry to help offer improved access and an extended range of services, integrating primary care with wider health and community services.

Cogora conducted a survey of 174 PCN clinical directors and a series of eight in-depth interviews with integrated care system (ICS) leaders and PCN clinical directors. We also analysed freedom of information data we received from commissioning bodies and publicly available data from NHS Digital.

We questioned leaders about their current challenges and opportunities within the PCN framework, how the pandemic has affected their PCNs, where they are spending their money and how PCNs fit in with other structures in the NHS.

About Cogora

Cogora is a leading, pan-European, full-service healthcare marketing agency. For over 30 years we have enjoyed a first-rate reputation for delivering top-quality, timely content that supports healthcare professionals with their clinical decision-making and career development.

Our portfolio of journals and websites includes *Pulse*, *Nursing in Practice*, *Management in Practice*, *The Pharmacist* and *Hospital Healthcare Europe*. We deliver national conference exhibitions – including *Pulse Live* – each year, as well as more than 100 smaller educational roadshow events across the UK. Engaging a community of more than 220,000 healthcare professionals, Cogora is dedicated to keep its digital and face-to-face channels growing.

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Executive summary

When NHS England published the *NHS Long Term Plan* on 7 January 2019, it guaranteed that investments in primary care and community services would grow by at least an extra £4.5bn a year over the period 2019 to 2024. Most of this money is set to be funnelled through new organisations – primary care networks (PCNs).
The 2019/20 GP contract, which came out of the *Long Term Plan*, includes an offering to practices called the Network Directed Enhanced Service (DES). This DES is a voluntary part of the contract, and requires practices to come together and form these new networks that mainly cover 30,000 to 50,000 patients. The contract provides a range of funding streams for the networks – from a core payment per patient, to money to pay for specific professionals to support general practices.

In return, the networks have been asked to focus on a number of requirements until 31 March 2024, which will evolve over time. This includes a requirement to offer routine GP appointments on evenings and weekends, and enhanced care in seven clinical areas. However, the rollout of these requirements has been heavily affected by the Covid-19 pandemic.

To assess how the first 16 months have gone, Cogora conducted a survey of 174 PCN clinical directors, followed by a series of eight interviews questioning PCN clinical directors and integrated care system (ICS) leaders.

Though 68% of the PCN respondents feel positive to very positive about the PCN project, some challenges are apparent. While clinical directors enjoy the opportunity to work together, the workload involved in their role is far more time-consuming than expected or costed; the additional roles reimbursement scheme (ARRS) that funds them to hire pharmacists, social prescribers and other roles is more inflexible than one would have hoped for; and even though PCN clinical directors mention they are likely to continue with the Network DES in 2021/22, they also feel they don't have any real choice.

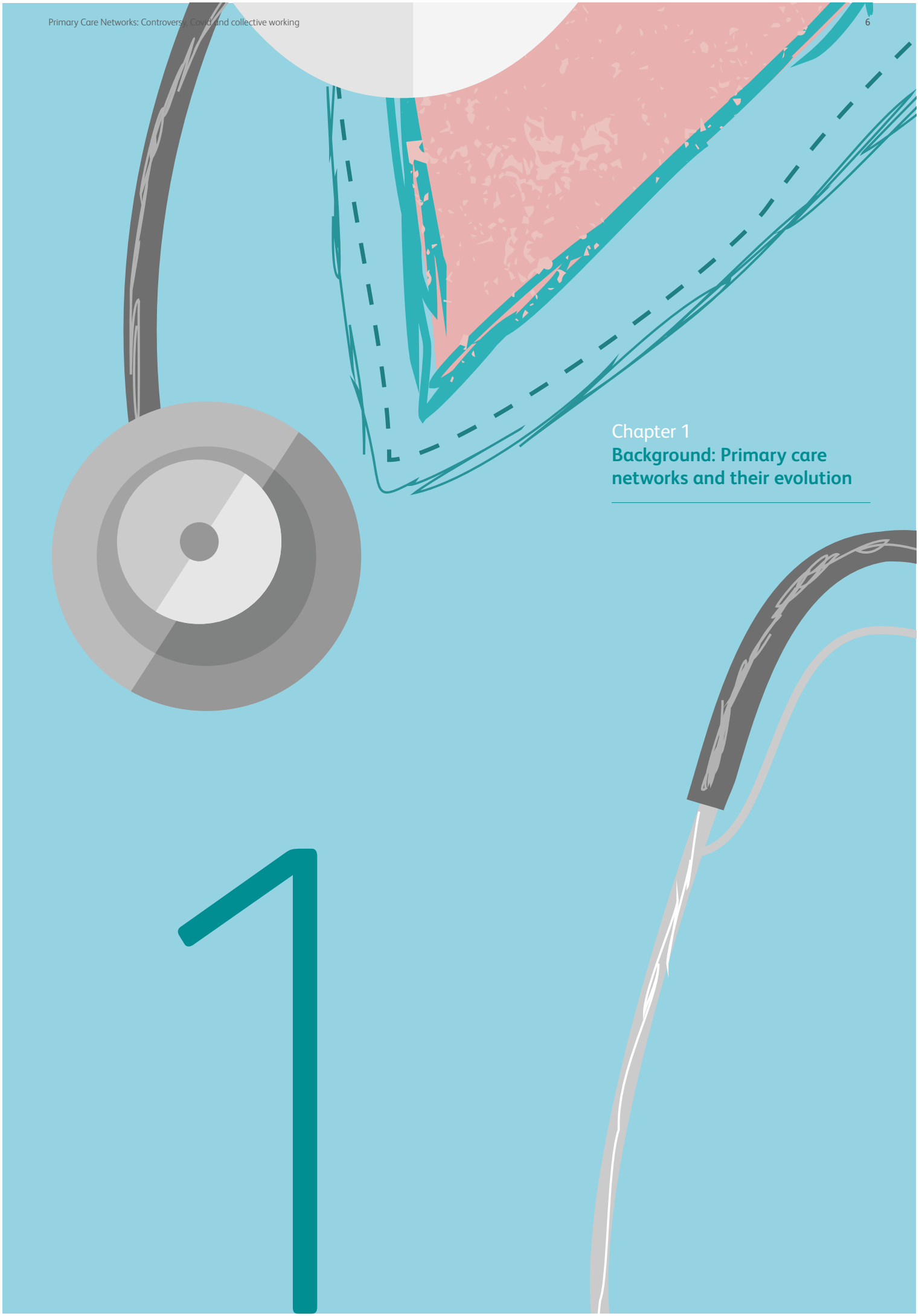
The biggest tranche of the funding comes from the ARRS, and common concerns include: struggling with recruitment for the specified roles; not being able to use all of the funding; inadequate funding; and the staff they need are not included in the scheme. This results in only 42% of the ARRS funding being used in 2019/20.

However, despite problems around funding, PCNs are clear as to what they expect to be spending their budgets on over the next five years, highlighting the importance of budgets for mental health and elderly care. Obviously, when the PCN project was initiated, no funding allocation could have taken a worldwide pandemic into account.

The Covid-19 pandemic seems to have galvanised the NHS around a single aim. Despite the terrible toll, it gave GP practices the final push to get online services going, it showed leaders how much time could be saved through online meetings, and the systems and networks put in place supported an agile and resilient response from the NHS. Now, PCNs have been thrust into the wider public consciousness since the announcement that the Covid vaccine will be delivered by 'PCN groupings', which are likely to mirror closely the PCNs themselves.

PCNs have been set up in the context of, and are involved in, other organisational changes within the NHS. The role of clinical commissioning groups is about to change, integrated care systems are on the up and there is an ongoing upscaling of general practice.

With all eyes focused on the pandemic, and primary care settling in with this new model to bring together care providers from health and social care, it is crucial for industry to stay up to date on how PCNs are evolving. Industry should know, engage, educate and support PCNs as their new NHS customer to improve local care.



Chapter 1

Background: Primary care networks and their evolution

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When Cogora's own *Pulse* magazine broke the exclusive that general practice was likely to begin providing Covid vaccinations before Christmas, it caused shockwaves across the world. As well as being the best news of the year, it also had the effect of thrusting primary care networks into the limelight.

Pulse reported that there would be around 1,000 to 1,500 GP-led sites across England delivering the vaccines, broadly aligning to PCNs, with these networks leading arguably the most important public health programme of the past 100 years.

This is a major responsibility for the newest major NHS organisations. Introduced in July 2019, the concept was designed to bring GP practices together to provide care for their local patient populations.

The 2019/20 GP contract detailed an array of funding for PCNs – from a core payment per patient, to funding for hiring specific professionals to support the work of general practice. In return, the networks would have to deliver a set of 'service specifications', including enhanced care for care homes and the management of medicines. Membership of the networks wasn't compulsory. Under the contract, it is listed as the Network Directed Enhanced Service (DES), meaning it is not part of GP practices' core work. Despite this, all but a few (2%) are signed up.

These networks are based on the GP registered lists and serve communities of around 30,000 to 50,000, although they can be larger (and, in exceptional circumstances, a little smaller). Practices work together with community, mental health, social care, pharmacy, hospital and voluntary services in their local area. There are currently 1,259 PCNs across England. They are not statutory bodies, but in future could form a legal entity, such as a limited company or a limited liability partnership.

They are led by a clinical director who must be accountable to the PCN, provide strategic and clinical leadership, work with other health and care leaders to advance the network's aims, carry out workforce planning and represent the PCN in the wider healthcare system.

PCNs' roots have been developing for years. They seem to be the end point (at least for now) of a number of government reforms designed to encourage collaborative working in the NHS and give GPs more power. As some NHS veterans will put it, 'there is nothing new under the sun' when it comes to service reorganisations.

Perhaps the origins of PCNs can be seen in the controversial GP fundholding of 1991, or the primary care groups (PCGs) of 1999, which sought to provide GPs with more power in shaping the local healthcare economy. These later evolved into primary care trusts (PCTs). These trusts were replaced by clinical commissioning groups (CCGs) in the 2012 Health and Social Care Act, which aimed to put clinicians at the heart of decision-making. The newly formed CCGs – clinically-led, statutory NHS bodies – manage the planning and purchasing of healthcare in their area. Crucially, it was mandated that all GP practices should be members of the CCG to ensure a strong clinical voice. There were 211 CCGs in 2013; mergers have led to 135 today. And it seems now they are being phased out completely (see chapter 5).

NHS England's *Five Year Forward View* in October 2014 encouraged collaboration between primary and secondary care providers through multispecialty community providers (MCPs) and primary and acute care systems (PACS). In 2015/16, there were 14 primary care-led MCPs and nine secondary care-led PACS vanguards selected to lead the way in collaborative working.

But take-up of the MCP and PACS project was not particularly successful, and GP practices themselves began organising into collaborative working arrangements to provide greater support to one another at a time when general practice was struggling. These took different forms: federations, networks, localities, hubs, neighbourhoods or super-partnerships.

One of the concepts that gained the most traction with strategic leaders and policymakers was the National Association of Primary Care (NAPC)'s primary care home (PCH) – themselves organisations of around 30,000 to 50,000 patients.

NHS England commissioned 15 rapid test PCH sites in 2015 that brought together care providers from health and social care to deliver preventative and personalised care for the local population closer to people's homes.

NHS England took note of this development, but with a new name. In March 2017's follow-up publication, *Next Steps on the Five Year Forward View*, PCNs were mentioned for the first time. It stated: 'Most GP surgeries will increasingly work together in primary care networks or hubs. This is because a combined patient population of at least 30,000 to 50,000 allows practices to share community nursing, mental health and clinical pharmacy teams, expand diagnostic facilities, and pool responsibility for urgent care and extended access. They also involve working more closely with community pharmacists to make fuller use of the contribution they make.'

However, there was still no contractual element to PCNs at this point. This changed with the *NHS Long Term Plan*, published on 7 January 2019, which brought us where we are today. It detailed a 'new guarantee that, over the next five years, investment in primary medical and community services will grow faster than the overall NHS budget'.

'This commitment – an NHS "first" – creates a ringfenced local fund worth at least an extra £4.5bn a year in real terms by 2023/24,' it stated. Importantly, most of this would be funnelled through the new groupings.

The requirements for PCNs to receive this funding set out in the Network DES is part of a larger long-term reform of the contract detailed in NHS England's *Investment and Evolution: A five-year framework for GP contract reform to implement the NHS Long Term Plan*. It's intended that there will be a Network DES each financial year until 31 March 2024, with the DES requirements evolving over time.

Currently, the Network DES requires PCNs to provide extended-hours access to routine appointments beyond their usual hours of work (normally 6:30pm on weekdays). This would be equivalent to 30 minutes per week, per 1,000 registered patients within the PCN. The number of patients includes those from practices that declined to join a network, but are within the PCN's locality. They also have to deliver a set of seven national service specifications, although the rollout of these requirements has been heavily affected by Covid-19.

Since April 2020, PCNs have been required to start work on early cancer diagnosis, which included reviewing practices' current systems, forming partnerships with local cancer organisations and conducting learning events, among other actions. They were also required to offer a 'social prescribing' service.

Since October 2020, the requirements have become more intense. They are now required to provide enhanced health in care homes. The original requirements for this stated that PCNs would have to provide fortnightly 'ward rounds' by GPs to care homes. Following huge controversy, this was watered down to providing these rounds weekly, but by any member of the multidisciplinary team. Also since October, PCNs have needed to deliver 'structured medication reviews' of vulnerable patients, to ensure their medication continues to be appropriate, and work with the CCGs to optimise the prescribing of antimicrobials and addictive medicines.

The remaining requirements are anticipatory care (with community services), personalised care, cardiovascular disease case-finding, and locally agreed action to tackle inequalities, although the details of these are still to be announced and are dependent on Covid-19.

To help them deliver these specifications, PCNs received funding to hire clinical pharmacists and social prescribing link workers through the additional roles reimbursement scheme (ARRS) in 2019/20.

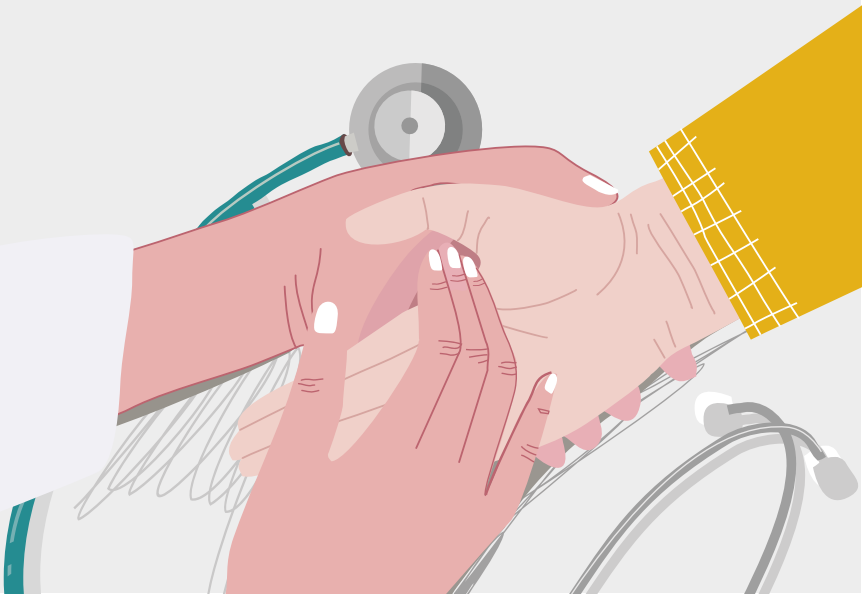
Pharmacy technicians, dieticians, podiatrists, occupational therapists, care coordinators, health coaches, first-contact physiotherapists and physician associates were later added. Mental health professionals, currently being piloted, will follow in April 2021.

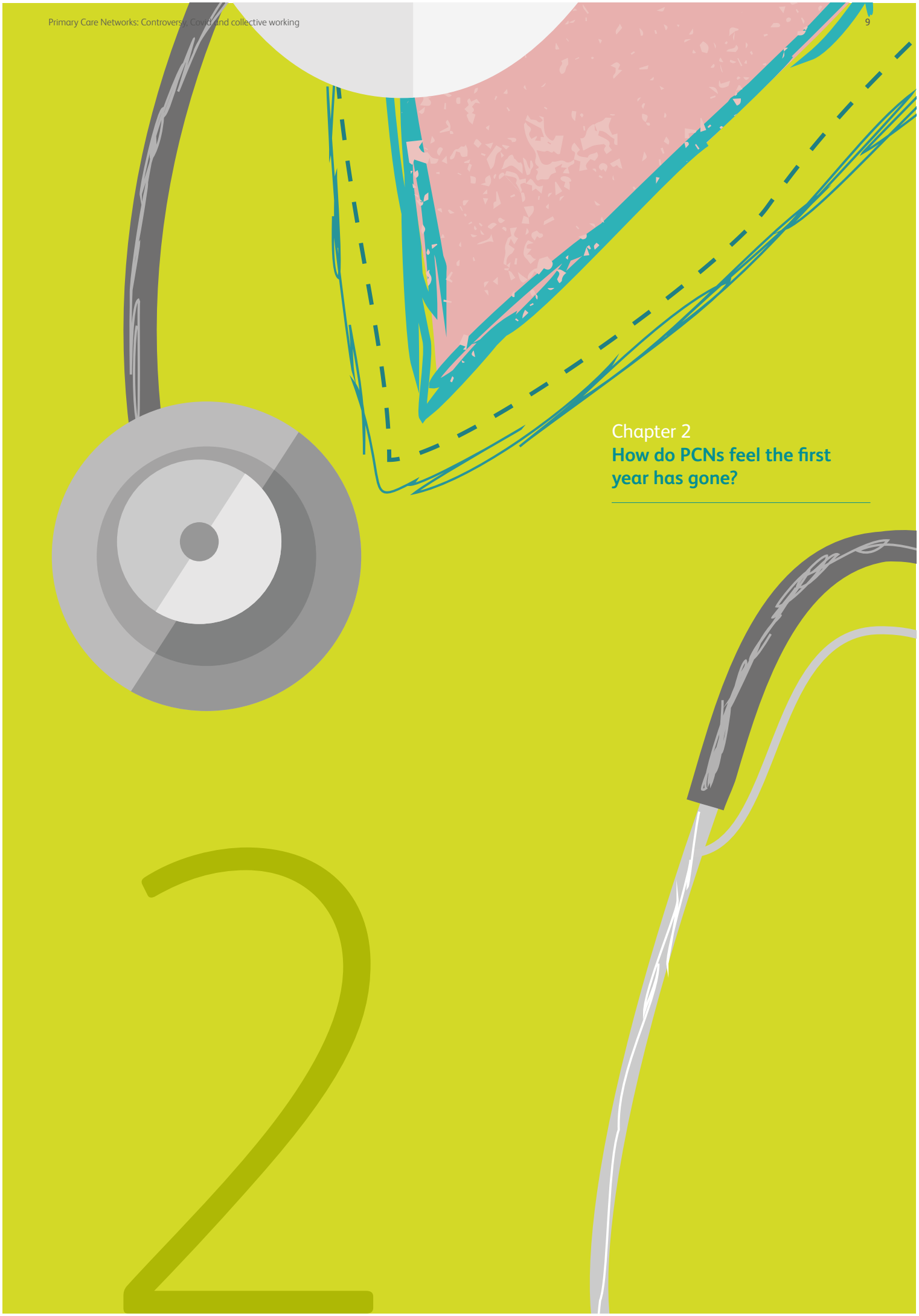
Now, they are being tasked with the Covid vaccination process. But even before then, the whole PCN project has proved controversial, as we will now examine.

> **"This commitment – an NHS "first" – creates a ringfenced local fund worth at least an extra £4.5bn a year in real terms by 2023/24.**

Key points:

- There are currently 1,259 primary care networks across England. They comprise GP practices coming together in a single organisation covering around 30,000 to 50,000 patients who collaborate with community, mental health, social care, pharmacy, hospital and voluntary services.
- They are the end point of the drive since the early 1990s to encourage greater collaboration between GP practices and give more responsibility to GPs in shaping the health service as a whole.
- The *NHS Long Term Plan*, published on 7 January 2019, outlined a commitment to invest £4.5bn by 2023/24 into primary care.
- The 2019/20 GP contract soon after confirmed that much of this would be funnelled through PCNs. It created a Network Directed Enhanced Service (DES) that requires PCNs to extend out-of-hours access for routine appointments, and enhanced care in seven clinical areas, including early cancer diagnosis and the provision of care home 'ward rounds'.
- There have been a number of positives, but the PCN project has proved controversial at times, due to concerns around funding and workload requirements.
- PCNs will lead on Covid vaccine delivery, collaborating to set up around 1,000 to 1,500 GP-led vaccination sites that broadly align to PCNs.





Chapter 2

How do PCNs feel the first year has gone?

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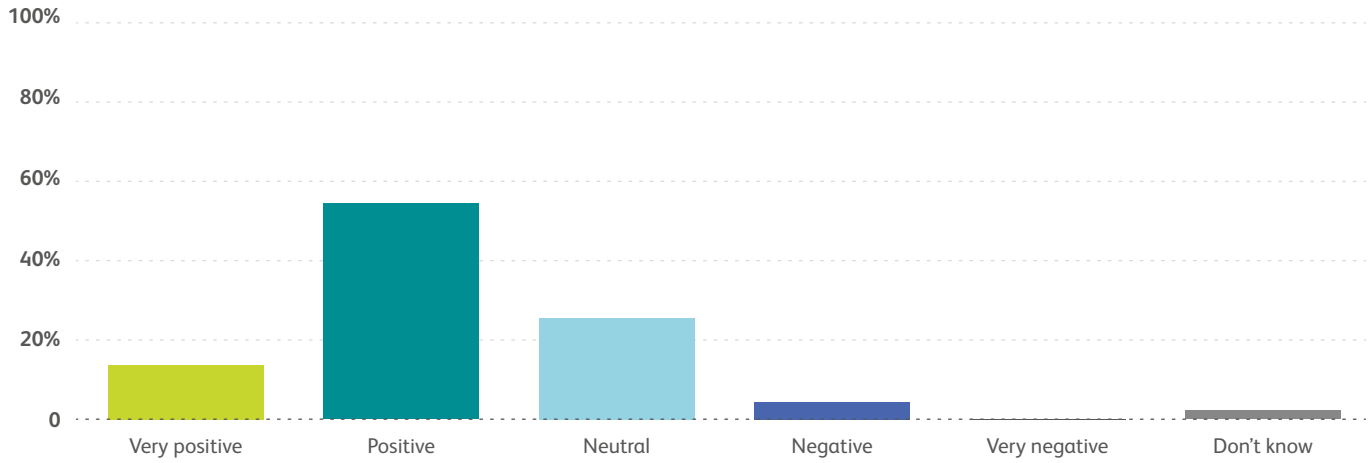
How do you feel about the PCN project as a whole?



The immediate response from the PCN leads surveyed by Cogora is overwhelmingly positive. The survey found that 68% of respondents feel positive to very positive about the PCN project as a whole, with less than one in 10 feeling negative.

Cannock PCN clinical director Dr Manu Agrawal says the 'collectiveness' brought about by PCNs is a positive that became particularly evident at the start of the pandemic. 'PCNs have given us a framework and a platform for neighbouring practices – which probably would not talk to each other or support each other – to communicate.

'Within our PCN, we've seen the positives...of working together, where we were supporting each other [during the first wave of Covid] with, say, PPE and staff and clinician shortages, and things like this,' he says.

Leaders of integrated care systems (ICS) – major new organisations that bring together NHS bodies and local authorities – interviewed were all in favour of PCNs as a natural evolution of their work and a way of empowering clinical leaders working in general practice. They particularly felt the benefit of being able to work with primary care at scale at the start of the pandemic (see chapter 4).

Rob Webster, lead chief executive of the West Yorkshire and Harrogate Health and Care Partnership, an ICS, says that the PCNs 'slot into our vision of the future', creating a strong foundation for the health system and the 'ability for primary care to have a provider voice'.

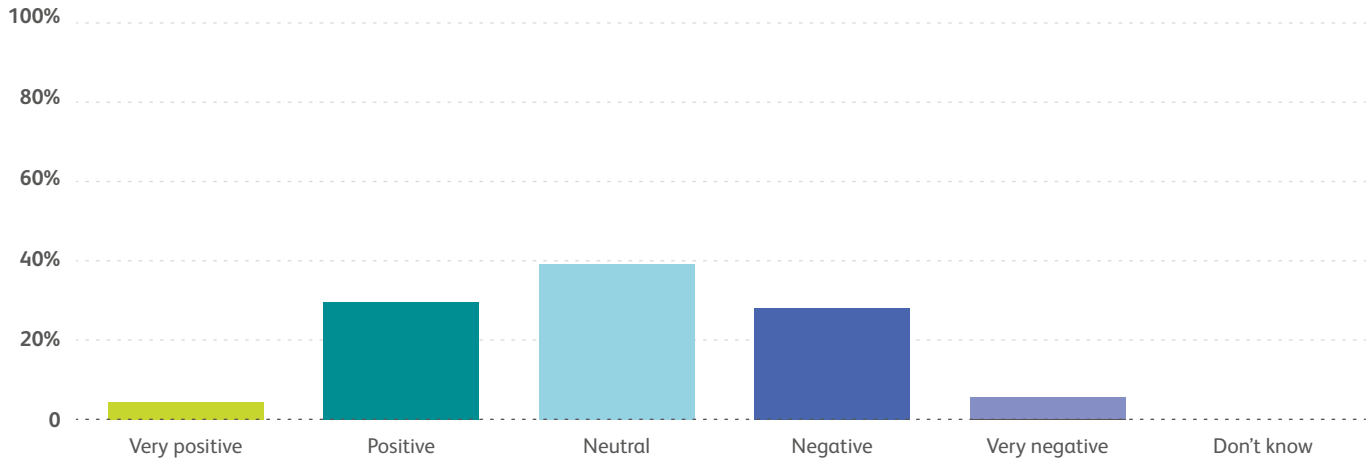
The region already had 50 'neighbourhoods' of 50,000 people, and it now has 52 networks.

'When primary care networks came along, I wrote to everybody and said, "Look, let's think about these in the same way; it's just the neighbourhood work we've been doing." It has freshened up some of the leadership, which has been a positive and a challenge...but gives great clinical leadership at that level,' says Webster.

> **"Significant investment has meant more people to do the work.**

> **"The best thing to happen to primary care in my 25 years as a GP.**

How have your feelings towards your PCN role changed?



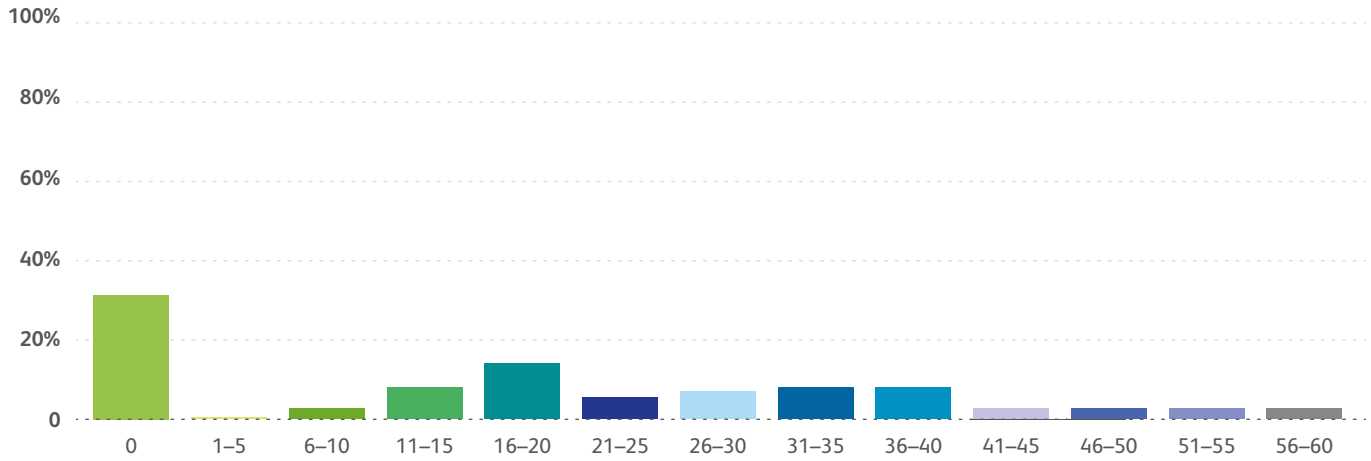
This was echoed by Dorset ICS lead and CCG chief officer Tim Goodson, who says that giving GPs the problem and a pot of money to solve them gets good results. 'We tried to be too prescriptive on the practices. GPs are great at problem-solving; that is probably one of their best skills. PCNs give more flexibility to let them do that,' he says.

But despite this positivity, there are challenges becoming apparent. When asked if their feelings had changed since they first took on the PCN role, the respondents were split, with 31% feeling more positive, 23% neutral and 31% more negative. Concerns range from the difficulty of setting up an organisation from scratch, and where it will fit in with the wider NHS structures (see chapter 5), to the demands of the clinical leader role and the restrictive nature of the DES.

The speed of setting up a PCN varies across the country. For some areas, slotting the PCN into the existing architecture was a fairly straightforward evolution, particularly where primary care homes were established.

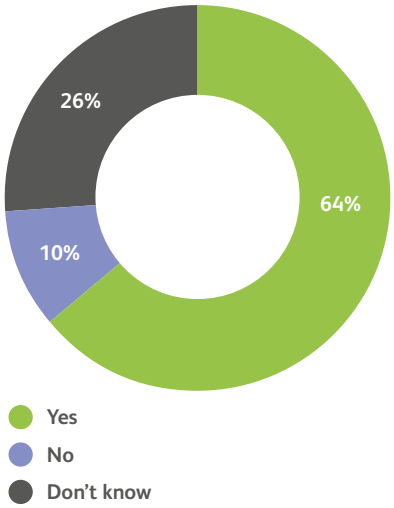
> **"The relaxation of some of the "rules" as to how PCN funds are used, and the more pragmatic performance management, has helped.**

Appointments per week lost through clinical director activity

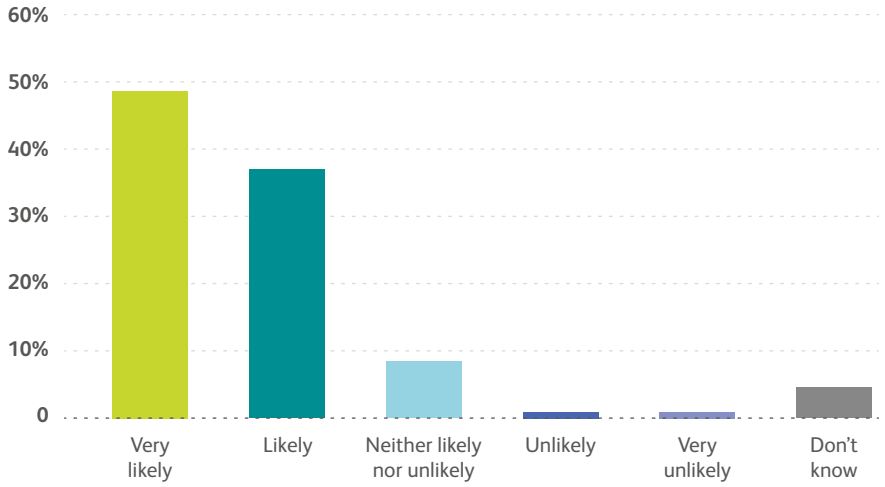


Chapter 2 – How do PCNs feel the first year has gone?

Will your PCN be able to fulfil its care home responsibilities?



How likely is it that your practice will continue with the Network DES in 2021/22?



Dr Brigid Joughin, clinical director for the Outer West PCN in Newcastle, says that PCH sites had a head start of 'two or three years and they just evolved themselves into a network. They got a lot of that grassroots stuff going, and then they're just morphing that with some of the new DES.'

The clinical director of the North Doncaster PCN in South Yorkshire, Dr Vijay Kumar, says that, while at practice level, getting GPs to 'play ball' has not been an issue, getting care out into the community is only just starting – but it has been happening for more than a decade in neighbouring Pontefract, West Yorkshire.

While clinical directors enjoy the opportunity to work together, the workload involved in their role is far more time-consuming than expected or costed (see chapter 3). It also eats into clinical time when there is a GP shortage.

Another challenge flagged up by clinical directors was the inflexibility of the additional roles reimbursement scheme, which provides funding for PCNs to recruit non-GP healthcare professionals (see chapter 3).

However, despite these challenges, and a global pandemic, most of the PCN leaders who took the survey (64%) felt they would meet the care home responsibilities – the most onerous of the requirements this year.

The overwhelming majority (86%) also say they are likely to continue with the Network DES in 2021/22. However, many of the comments in the survey centre around there being no real choice not to. And it seems that grassroots GPs are not as supportive of the project as a whole. On 27 November, delegates at the BMA's local medical committee conference, who represent GPs on the ground, voted to put the whole DES out to ballot. Many of the problems with the DES centre on the funding – which we shall now see.

> **"I have reduced a clinical day to accommodate PCN and ICP management duties.**

Key points:

- PCN leads surveyed are overwhelmingly positive about the project as a whole: 68% of respondents feel positive to very positive about it, with less than one in 10 feeling negative.
- GPs have already seen the benefits of collaborative working, especially when the pandemic hit. Integrated care systems leaders see PCNs as way to give GPs greater responsibility and flexibility.
- Some challenges are becoming apparent: feelings towards PCNs have already changed, with 31% feeling more negative than at the start of the project, 23% neutral and 31% more positive.
- Difficulties have included setting up an organisation from scratch, the demands of the clinical leader role and the workload involved in the requirements set out by NHS England.
- An overwhelming majority (86%) say they are likely to continue with the Network DES in 2021/22, but there is a feeling that not doing so is not an option.

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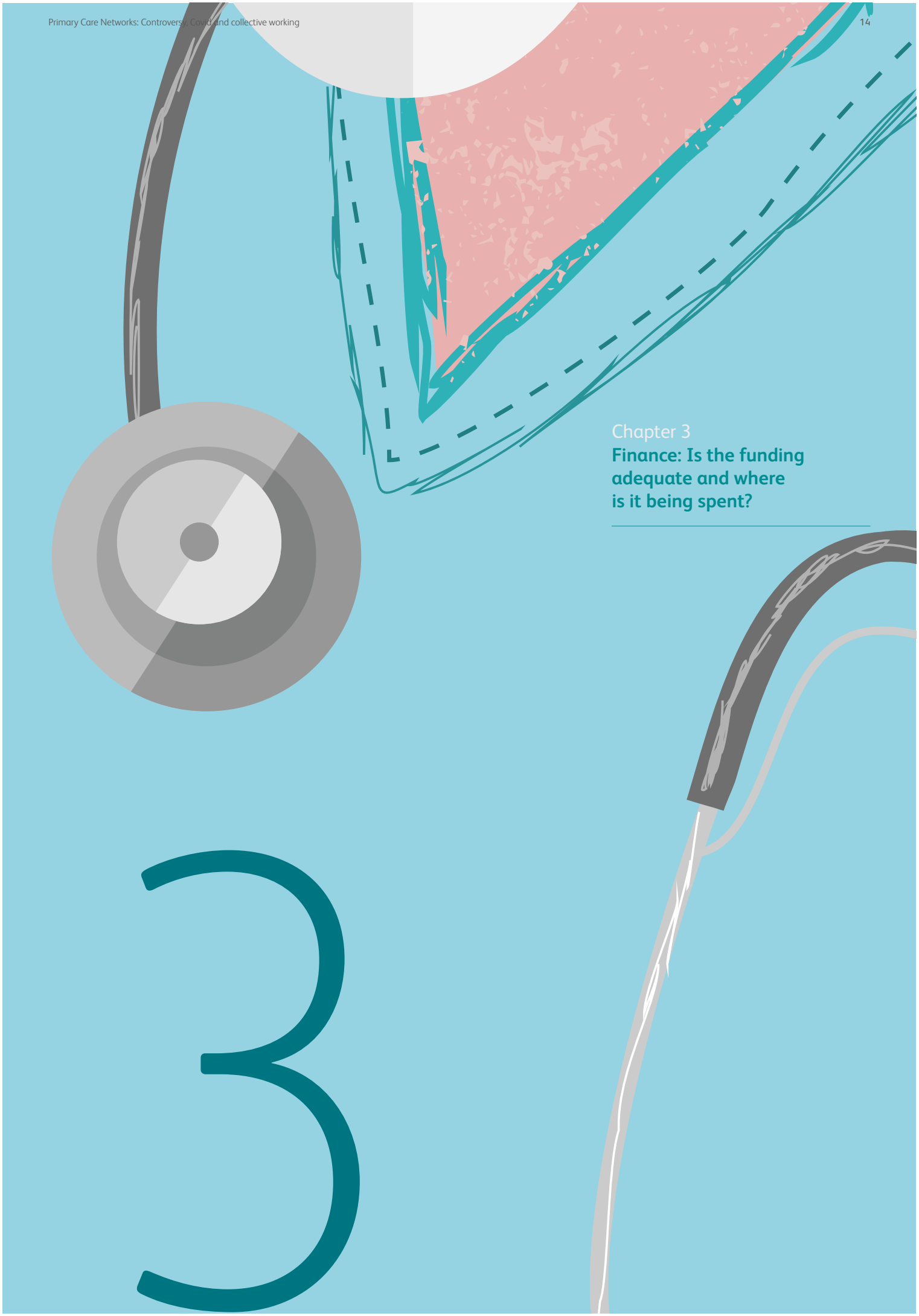
It is worth continuing with the commitments as it is far too early to say the reorganisational changes have had a positive or a negative impact. Too much disruption this year.



Chapter 3

Finance: Is the funding adequate and where is it being spent?

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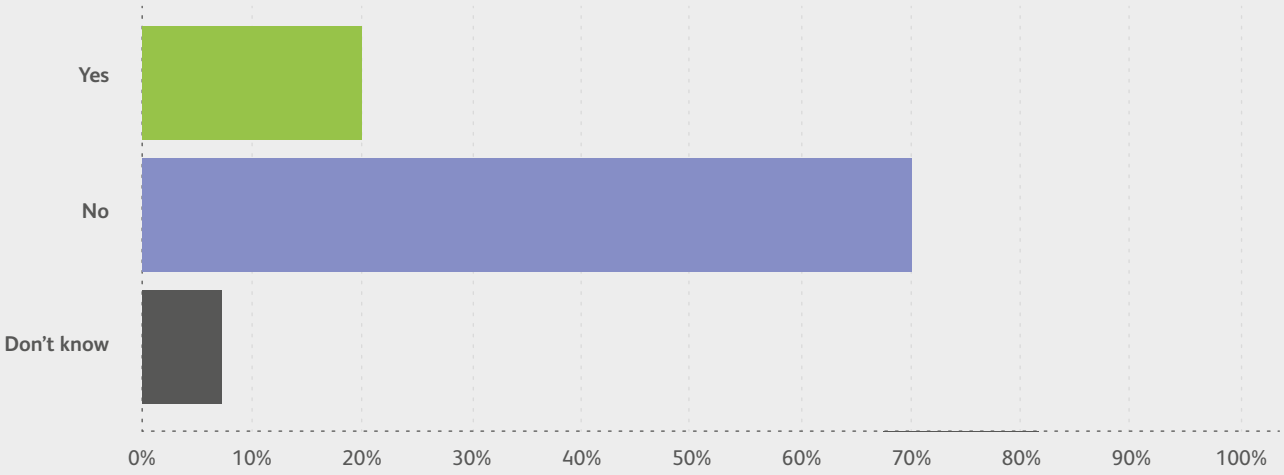
Do you think the resources PCNs are being given in 2020/21 are adequate for the workload requirements set out in the DES?



It is widely agreed that the funding for PCNs is what spurred the majority of GP practices to sign up. It is also agreed that the funding is not enough. Three-quarters (72%) of respondents to our survey said it was inadequate.

The total funding for joining a network equates to around £350,000 to a PCN of 30,000 patients, according to the BMA, and it looks certain they will soon be the main recipients of primary care funding, ahead of individual practices. The current funding includes £1.50 per patient core funding for the network. Alongside this, they receive 72p per patient to reimburse a clinical director's time, £1.45 per patient for providing extended-hours, reimbursement for additional roles at an average of just over £7 per patient, and £60 for every care home bed within the network. They will also receive 67p per patient for achieving the requirements of the 'impact and investment fund', based around flu, learning disabilities and medicines safety measures.

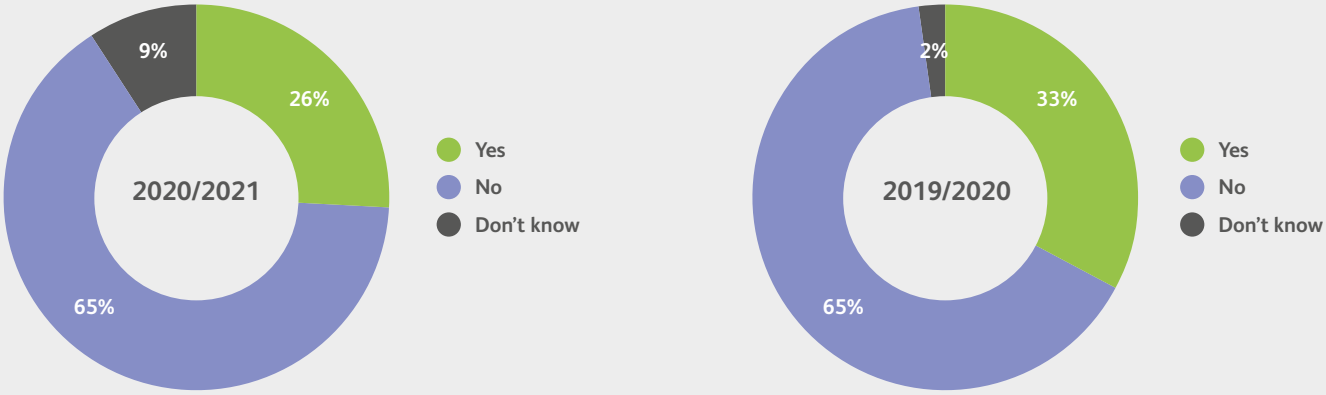
ARRS challenges

The biggest tranche of funding is the additional roles reimbursement scheme (ARRS), which funds the recruitment of non-GP staff – including £55,000 per year for a clinical pharmacist and £35,000 for a 'social prescribing link worker'. But a number of problems have become apparent: PCNs are struggling to recruit, meaning a lot of the money is actually lost; the funding is inadequate when they do find someone; and the staff who are actually needed aren't included in the scheme.

The challenge of recruiting for the specified roles is highlighted in the survey, with 65% of respondents saying they have been unable to fill roles in both 2019/20 and 2020/21.

> **"The resource via funding is very generous, but we feel we need to be able to make our own decisions about the roles we need.**

Has your PCN been able to fill all the roles under the Network DES additional roles reimbursement scheme?



Part of the recruitment challenge is that neighbouring PCNs are fishing from the same pool, as are other providers. Dr Ed Garratt, executive lead for the Suffolk and North East Essex integrated care system (ICS), who is also lead commissioner of the East of England Ambulance NHS Trust, says: 'We've been keen to have a collaborative approach with the ambulance trust and the PCN. We don't want an exodus of paramedics to the PCN, but the PCN also needs paramedics, so taking a rotational approach, where everyone has more of a share of resources, is really important.'

As a result of the problems recruiting, much of this money promised to PCNs hasn't materialised. A *Pulse* freedom of information (FOI) request found that only 42% of the available funding was used in 2019/20.

NHS England guidance advised that any ARRS money not spent should be reinvested into other PCN work. However, *Pulse*'s FOI request found that 22% of the ARRS funding – equating to around £24m when extrapolated across England – was still unspent in June, two months after the end of the 2019/20 scheme, while 36% was spent on 'other activity'.

> **We haven't recruited that many yet due to organisational issues and funding but are optimistic about this increasing now.**

42%

of the available additional roles reimbursement funding was used in 2019/20

22%

of the available additional roles reimbursement funding was still unspent by June 2020

> **With the lower level of funding, you obviously don't get people who are that qualified.**

Chapter 3 – Finance: Is the funding adequate and where is it being spent?

As well as this, those interviewed found that the funding did not actually cover the costs of the new staff, particularly once training and pensions were taken into account.

Cannock's Dr Agrawal says low funding fails to attract experienced applicants: 'With the lower level of funding, you obviously don't get people who are that qualified. Now, the whole idea of the PCN that was sold to us was that this would help practices in terms of their time capacity. However, that is now being substituted by training these people up,' he says, adding that once trained there is no guarantee new recruits will remain in the service of the network.

He says the real cost of a clinical pharmacist is 'between £60,000 to £65,000 for someone who can come in independently and hit the ground running', when national insurance and pensions are taken into account. 'The £55,000 provided by the ARRS does not give you an independent clinical pharmacist. That's where a lot of PCNs are struggling. That needs to be looked at.'

Once hired, the costs mount. The new recruits need training, support and a place to work from. Dr Agrawal explains that a particular challenge is 'having a lack of estate facility'. He says: 'With all these roles, it's about employing them, but it's a challenge housing these people. With Covid it's become more of a challenge because of social distancing; you can't have two people working in the same room.'

A survey by National Association of Link Workers in June paints a grim picture. It found that 29% of social prescribing link workers – who support patients in identifying the appropriate healthcare social care or voluntary organisations for their needs – were considering resigning their post in the next year due to lack of support and/or clinical supervision. More than three-quarters of these (77%) are based in general practice.

PCNs have tried to find ways of mitigating these extra costs. In Newcastle, the local trust has done some of the recruitment on behalf of the PCN, helping with training and support for prescribers who are part of a wider hospital-based team. Newcastle's Dr Joughin explained that all the PCN roles have been employed through a third party. 'All pharmacists in all the Newcastle networks are employed through Newcastle Upon Tyne Hospitals NHS Foundation Trust,' she says. 'They thought this would be a good idea, and they have taken it upon themselves to recruit within the trust but working for the network.

'There's probably about 16 of them now, so they don't feel so isolated being a network pharmacist, which is a totally new role. The trust is providing their training, so it's quite a good package for us.'

Dr Joughin, who is also on the PCN Network Board, worked with a local charity, Mental Health Concern, to ensure her PCN also got link workers with experience.

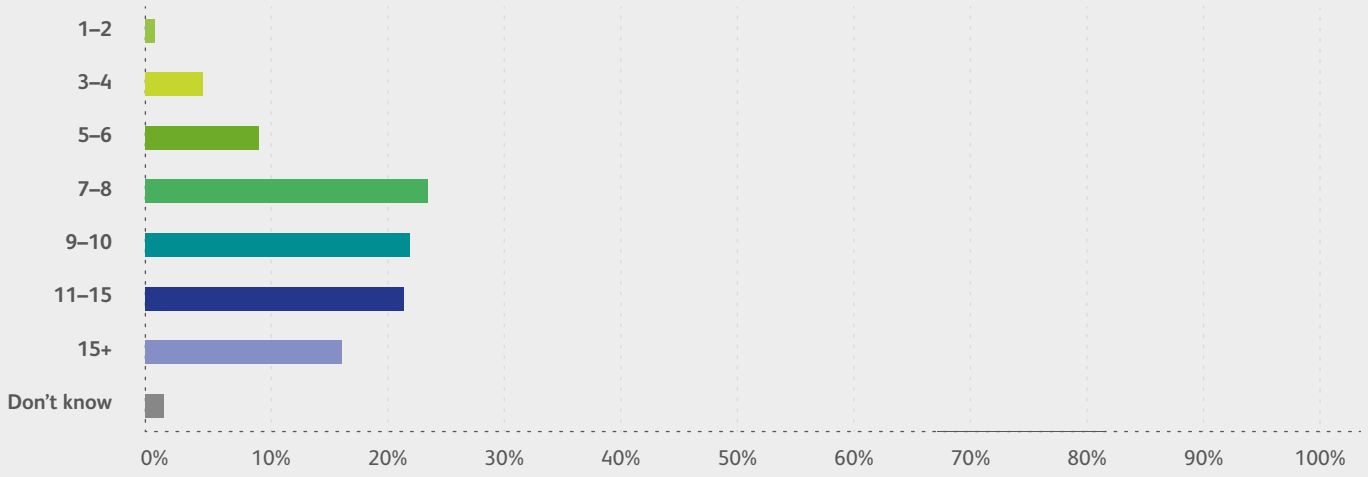
But then there is the final problem – the fact that the roles offered are not those that are needed. Dr Joughin says: 'If you ask any GP or clinical director, they will all cry out, "We need more help for people with mental health problems." And it's the one role that is not included in the list. So, who thought that up? Somebody who never worked in general practice, because they would not put a podiatrist ahead of a mental health worker.'

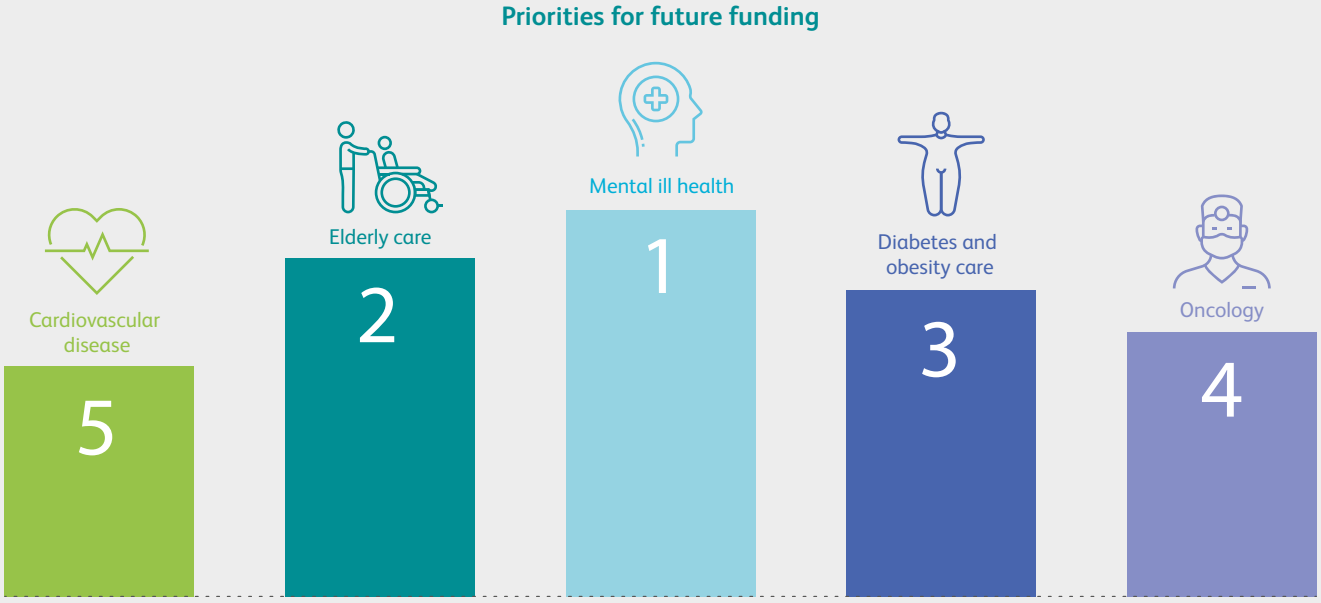
Others pointed to the need for advanced clinical practitioners (ACPs) and phlebotomists.

Funding deficit

Although the ARRS is the main source of contention when it comes to funding, there are other areas of concern. The survey found that clinical directors were regularly spending more time on their PCN work than was actually being funded.

How many hours per week do you spend on clinical director activity?





Around two-thirds (61%) are spending upwards of nine hours a week on clinical director work, and a third of those (16%) are spending more than 15 hours a week. Many of those reporting they worked less than eight hours a week commented that they were in a job share.

In Doncaster, Dr Kumar says that while he's only paid for five or six hours to carry out his clinical director work, he spends between 14 and 16 hours a week on the PCN role. 'You're doing a lot more. It requires a lot of energy – you need enthusiasm to actually do the work. The CCG wants you to contribute more and I keep reminding them that we are only starting at the moment. Yes, we have a lot of enthusiasm, but it needs to be mastered with time and experts, and getting locums into the practice,' he says.

Dr Joughin used an app to track her clinical director hours and found she worked 14 hours a week. 'Two four-hour sessions does not cut it at all; we just do it in our own time and that's voluntary. There's a lot of unpaid work. To not have money for managers is ridiculous. For the smaller practices, smaller networks, there's mostly the same amount of work for a clinical director and yet the money is proportional to size, but the work is not proportional to size.'

Dr Joughin's PCN employs a manager but has had to ask for extra funding to support this. 'As we're getting more employees and things are getting busier, a lot of PCNs are now employing PCN managers. We've got one who just started this week [September] and there is no money, so that has to come out of the £1.50 per head core funding. Again, that is very difficult; it is a real stretch for smaller PCNs in particular.

'NHS England is going to have to look at that and realise there needs to be some provision, because a few sessions with a clinical director a week does not run a network when you're employing 20 people.'

However, despite this funding deficit, PCNs are clear about what they expect to be spending their budgets on in the near future. When asked about which clinical areas the clinical directors think PCNs will be spending on in the coming years, 40% said mental health, followed by elderly care (36%), and diabetes and obesity care (14%).

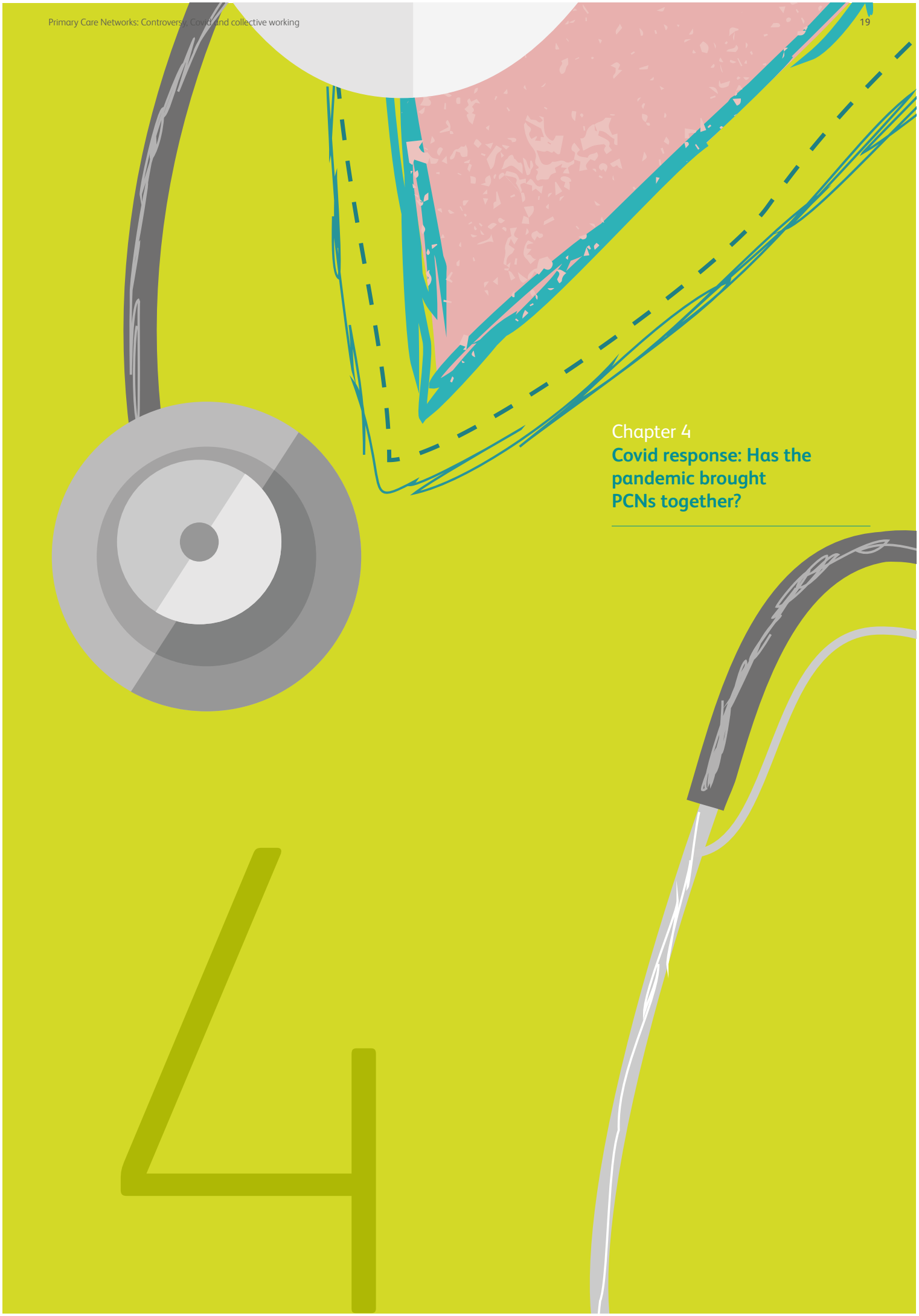
These issues are not adequately reflected in the allocated funding. There is hope that NHS England will look again at this.

Of course, when the PCN project was first conceived, no funding allocation took into account a pandemic hitting just as they were taking off. Yet Covid has helped highlight the role of PCNs, as we will see in the following chapter.

> **"I am certainly working harder than when I was a CCG governing body member and locality lead.**

Key points:

- The BMA estimates the current funding for PCNs equates to around £350,000 for a PCN of around 30,000 patients.
- The promised funding for PCNs is what compelled the majority of GPs to sign up, but 72% of respondents agreed that the funding was inadequate.
- The additional roles reimbursement scheme (ARRS), which funds PCNs to hire additional staff such as pharmacists and physiotherapists, makes up the bulk of the funding.
- There are a number of issues with the ARRS, with concerns that the funding is inadequate and focuses on the wrong staff members.
- There are problems with recruitment – 65% of respondents say they have been unable to fill roles in both 2019/20 and 2020/21. This has meant that much of the money promised to PCNs hasn't materialised, and *Pulse* found that only 42% of the available funding was used in 2019/20.
- One big concern is that clinical directors spend more time on PCN work than they are funded for: around 61% spend more than nine hours a week on that work, which takes GPs away from frontline patient care.
- Clinical directors think PCNs should focus on mental health (40%), elderly care (36%), and diabetes and obesity care (14%). These are not currently reflected in the funding, but there is hope this will be reassessed.



Chapter 4

Covid response: Has the pandemic brought PCNs together?

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What no forward view or long-term plan could foresee was a global pandemic that would require GPs to conduct all possible appointments online, and hospitals to halt planned procedures and clear beds in preparation for a tidal wave of critically ill, contagious patients in need of intensive care.

The fear was that hospitals would be overwhelmed. But the first seven-week national lockdown, starting on 23 March, slowed the spread of the virus, and the systems and staff within the NHS managed.

This time of crisis galvanised the NHS around a single aim. Despite the terrible toll, it was the pandemic that gave GP practices the final push to get online services going. It showed leaders how much time could be saved through online meetings, and where the systems and networks put in place supported an agile and resilient response from the NHS. And this knowledge is now available as they prepare for the rollout of the vaccine.

Supporting structures

Both system and clinical leaders believe the years of work laying down the foundations of closer working between health and care organisations enabled them to act quickly and remain resilient through the crisis.

Jane Milligan, executive lead for East London Health and Care Partnership and chief executive of the North East London Commissioning Alliance, says that existing relationships and infrastructure meant they could quickly pull together and establish an incident control centre and a programme of work with designated leaders.

'The CCG chairs did a lot of work with their individual boroughs, establishing webinars and setting up weekly or biweekly support sessions as a place where people could get the information about how to switch to digital, etc,' explains Milligan.

'Certainly from a PCN perspective, we were very much connected into that level. I think we very quickly stepped up our services with a really fantastic joint approach.'

Dr Garratt of Suffolk and North East Essex ICS says PCNs were vital in establishing resilience: 'During Covid, we've really seen the benefit because the practices have collaborated so well together to keep an excellent service on the road. If we hadn't invested in PCNs, we may not have seen that resilience during the pandemic.'

The biggest area of collaboration has been how to deal with Covid cases while protecting staff and patients. Hot and cold or red and blue practices were established in the community to deal with suspected Covid and non-Covid cases; practices supported each other and shared information.

In West Yorkshire, with its 52 PCNs, Webster says the 'ability to operate primary care at scale has been fantastic'. He adds: 'The Covid and non-Covid sites have operated really well in all of our places, and the PCNs have had a really good role to play in that, working with CCGs. We follow [the maxim], "Real change happens in real work." Where the CCGs and primary care networks have had to work together closely on red/blue, hot/cold, Covid/non-Covid sites, it has really driven that agenda.'

Doncaster's Dr Kumar says: 'We've always been fairly cohesive here. In terms of the pandemic, we try to help each other. We trained the pharmacists to work from home. We helped our nurses to make sure policies were shared, common interests looked after, etc. I put in place a buddy system. If one practice went down and patients suffered, the other practice would support it. We already had a system in place when we had the floods in South Yorkshire.'

Newcastle's Dr Joughin says that having to work in the pandemic further strengthened the PCN, although it has, inevitably, delayed plans. 'Given we'd had a year of coming together, it was really helpful, because our practices have a good working relationship. We were having weekly Teams calls with the network board about, "How to cope with Covid. Have you got enough PPE?"

'It was much easier for the federation and the CCG to feed things out and get feedback because we had that ready-made coverage of the city, which you wouldn't have had pre-PCNs.' But, she adds, it 'certainly stalled a lot of actual PCN work'.

The sharing of, at times scarce, personal protective equipment (PPE) was also mentioned as a huge positive. Dorset's Tim Goodson says: 'People were sharing PPE. When push came to shove, people actually did it. There wasn't a question about, "Why do we need to share this? This is ours." The PPE moved around the hospitals and the people just gave it to those who needed it.'

Finance and technology

Goodson highlights the speed with which things got done in Dorset, helped by guarantees from the NHS and government to provide all the financial support necessary. 'One of the positives we've seen is that it gave everybody a single objective. You saw a much closer alignment of NHS and local authority.

'I've never seen the hospitals empty so quickly. Local authorities, GPs and care homes all played a part in that. It aligned the financial incentives and objectives 100% – and that was great to see,' says Goodson.

Milligan agrees: 'If you tell people to get on with it and don't worry about the money, that, of course, removes some of the barriers.'

Technology also took a giant step forward at the start of the pandemic. Goodson says that in Dorset – where, like much of the country, 100% of practices now have capabilities for online/video consultations and telephone triage, up from 70% before the pandemic – the technology leap has been massive. 'Everybody opts for a different way of working going forward. There's no real escape from that. You've

got to embrace new ways of working and the new technology. I found it really quite good. We saw all the partners coming together on Teams meetings – everybody was there. If you were going to that meeting before, it would probably have cost you a morning or an afternoon, whereas now you know it's going to cost you an hour, and everybody will be there,' he says. 'It increases the decision-making speed and responses massively. This led to time savings through Teams meetings,' he says. 'I think it will continue post-Covid, because you save so much time. I probably saved two and a half hours a day in efficiency. I would not want to lose that sort of thing now.'

The Covid vaccination programme

The process of looking at what has worked well and can be carried forward is already underway. West Yorkshire's Webster says: 'What we need to do now is look at how we pick up all the great stuff we've done during the pandemic and put it into planned work – like making sure people with a learning disability get a health check. Doing better at scale across primary care, that kind of thing.'

Goodson says this really showed what everyone can do when they focus on one thing. 'One of the learning points is that, because there are so many priorities, everything gets confused. Whereas when we got to focus on Covid, on that same thing, it is amazing what can be achieved.'

PCNs have an immediate chance to show this. The Covid vaccination programme is being delivered through one vaccination site per PCN grouping. The groupings won't correlate precisely to the PCN groupings – practices that have declined to join a network are able to take part in the PCN groupings and, depending on size, a PCN may have two vaccination sites, or join with another network to offer a single site between them. NHS England predicts there will be around 1,000 to 1,500 PCN vaccination sites. To put this in context, *Pulse* received a document from NHS London estimating that the 197 PCNs in the capital will provide around 140 sites.

However, PCN clinical directors are concerned about the scale of the challenge. A *Pulse* survey of 205 directors revealed that 66% warned their PCN member practices would have to stop other GP work to deliver the vaccination programme. Around 59% said the fee for the vaccine – £12.58 per dose administered – was inadequate, including 38% who said they would be making a loss.

The majority of directors would be signing up, but many out of a sense of duty. One, who asked to remain anonymous, told *Pulse*: 'We decided not to take on the [vaccination programme] due to the logistics, managerial time, organising it all at short notice, having to work at weekends, bank holidays – and that's with everyone fit and well and not having to self-isolate.'

Where PCNs fit post-Covid depends on the NHS structure as a whole going forward, which we will discuss in the next chapter.

Key points:

- The established collaborative working of the PCNs enabled them to act quickly and remain resilient throughout the pandemic, including an almost overnight shift to remote consultations and caring for patients who would normally have been under the care of hospitals.
- Practices worked within PCNs to share resources, including PPE, and to take on the task of carrying out the biggest flu vaccination programme ever.
- This experience will help them carry out the Covid vaccination programme, but there are already concerns around the funding and whether they will be able to achieve it.

> **"If we hadn't invested in PCNs, we may not have seen that resilience during the pandemic.**

CASE STUDY: PCNs coming together

The government announced that the biggest-ever flu vaccination programme will be taking place this year, in an attempt to prevent a damaging flu season during the Covid-19 pandemic. However, this has to be done at a time of social distancing and a shortage of flu vaccinations, leaving GP practices with logistical problems.

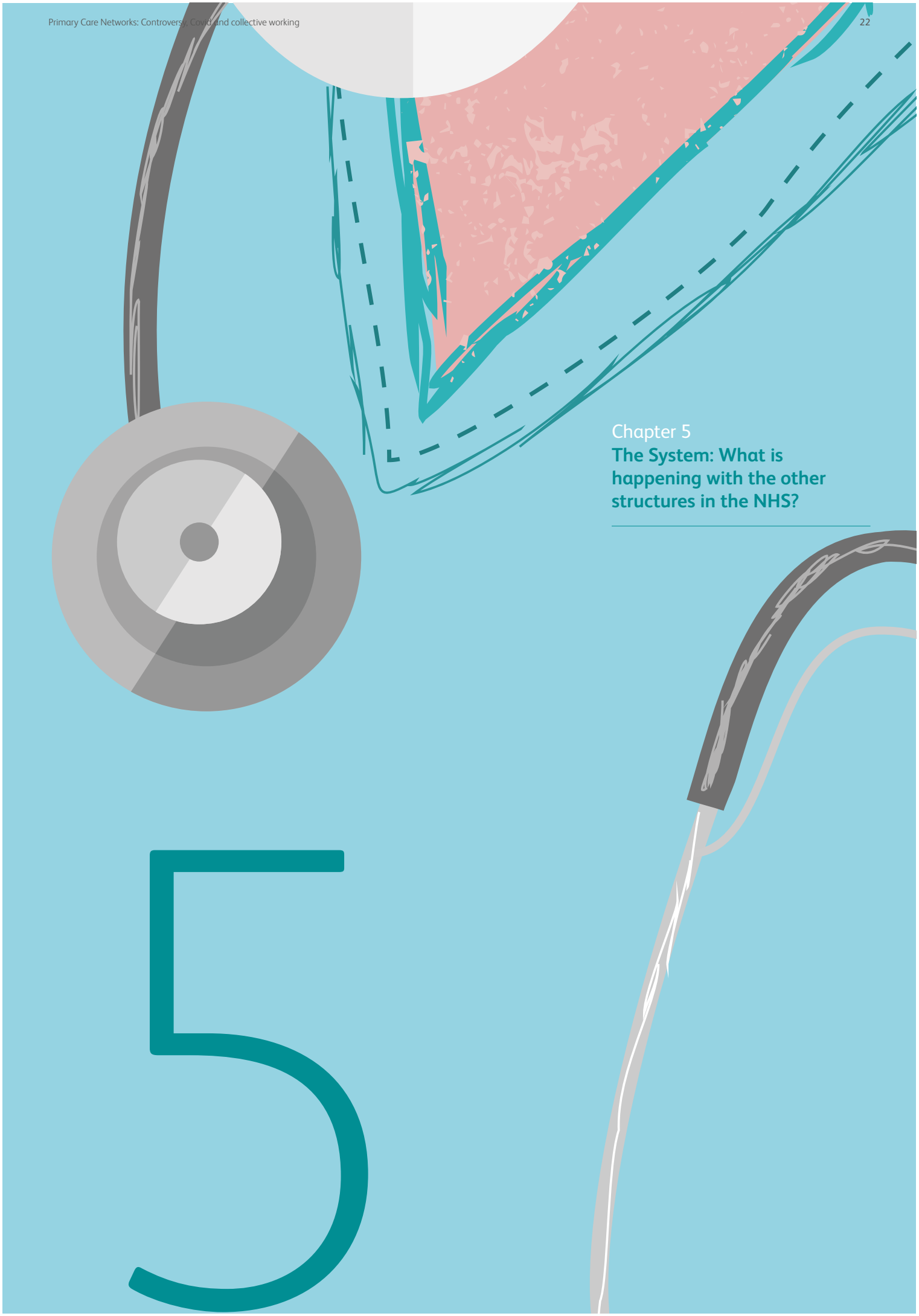
In many areas, PCNs came together to solve these problems. Back in June, the eight practices in Hyde PCN in Greater Manchester decided to pool their vaccines and set up a drive-thru vaccine system in a large leisure centre car park. With the help of Health Innovation Manchester, which is evaluating the scheme, they got the technology in place to allow online bookings for all patients – similar to the Covid-19 swab system.

'We have around 25,000 vaccines to do, but we were still 9,000 short, so we agreed with the 13 local pharmacies in our patch that they will provide a walk-in service, with bookable appointments, for those who don't have cars,' PCN manager Sally Culmer says.

Healthcare assistants have been delivering the drive-thru vaccination service with the help of community nurses. A lot of work has gone into the financial and administrative systems to allow this to happen and ensure practices are still reimbursed, she adds.

Starting on 21 September for 10 hours a day, five days a week, patients were able to book appointments to drive into a covered space between two portacabins, or use their pharmacist's walk-in service.

'We felt this was the safest way to do it,' says Culmer. 'We knew this would not have been feasible through practices.'



Chapter 5

The System: What is happening with the other structures in the NHS?

5

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These PCNs have been set up in the context of a number of other organisational changes within the NHS, including the introduction of integrated care systems (ICSs), potential phasing out of CCGs' commissioning functions and the ongoing upscaling of general practice. PCNs are a factor in all these changes.

ICS/STPs

The *NHS Long Term Plan* states that ICSs will cover the whole of England by April 2021. They will build upon the work done by their predecessors, sustainability and transformation partnerships (STPs), which were set up in 2016. The ICSs bring NHS and local authorities together to better care for their populations. Moving to an ICS gives leaders greater freedoms to manage the operational and financial performance of services in their area, the plan says. Of the original 44 STPs, 18 have progressed to ICS status. Currently, they cover all of the north of England and patchwork the south.

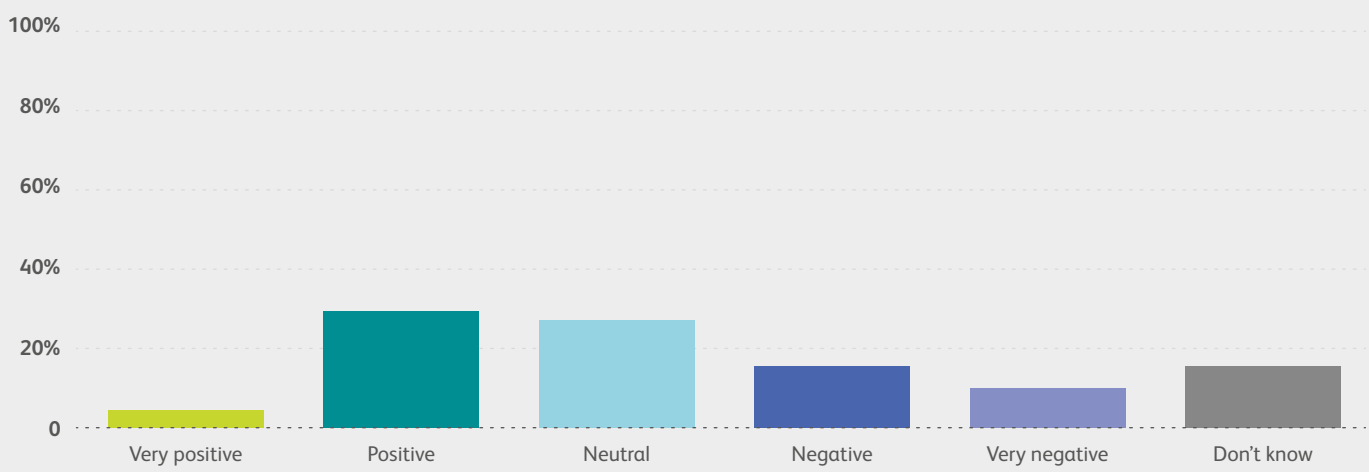
Respondents to the survey were divided on their view of the plan to have all of England covered by an ICS. The majority (32%) believe it will have a positive effect, 27% think it will have no impact, and 25% feel it will have a negative impact.

Possible legislation is on the horizon, with the Health Service Bill, which has been recommended by NHS England and NHS Improvement. It would strengthen the power of ICSs by, among a number of things, removing barriers around how an ICS can spend the 'NHS pound' and supporting the efficacy of ICSs by letting trusts and CCGs form joint committees and make legally binding decisions.

The *NHS Long Term Plan* states: 'This is simpler and less expensive than creating an additional statutory tier of bureaucracy. It would mean giving NHS foundation trusts the power to create joint committees with others. It would allow – and encourage – the creation of a joint commissioner/provider committee in every ICS, which could operate as a transparent and publicly accountable partnership board.'

> **"If an area has an ICS that is truly collaborative, coordination and continuity of care will improve for its population, and sustainability of the workforce, along with morale, should benefit.**

What effect do you think NHS England's plan for the whole country to be covered by integrated care systems will have?



The ICS leaders interviewed all hoped that any legislative change would not be too prescriptive. 'Our success is built on having good governance and good relationships, and anything that is done legislatively needs to support that,' says West Yorkshire's Webster.

'My worry is that you end up trashing one or the other if you get the rules wrong. The NHS can be pathological about structure. We've been able, pre-pandemic, to make the decisions and choices about reconfiguration of services, which have been potentially very contentious but have been happening without a formal legislative footing for the ICS as a thing,' explains Webster.

'Then, in the pandemic, the ICS has been fundamental to our success, as a system, in business continuity and maintaining services, PPE supply, testing – a whole raft of things that have meant we've succeeded as best we can during this period.

'There's a big push, nationally, to make sure we strengthen systems, but let's make sure that's done in a way that doesn't wreck good things that are happening already,' he adds.

The *NHS Long Term Plan* states that every ICS will have a partnership board that includes representatives from PCNs and 'full engagement with primary care, including through a named accountable clinical director of each PCN'.

ICSs are at varying stages of work around this. East London's Milligan says: 'I would be looking for PCN leaders to put themselves forward. We would have to look at how we financially support that, because, obviously, within the PCN contract, it's supposedly pretty tight. We're asking a lot of PCN and clinical leaders at the moment, but there is an opportunity to develop roles that PCN leads can step forward for.

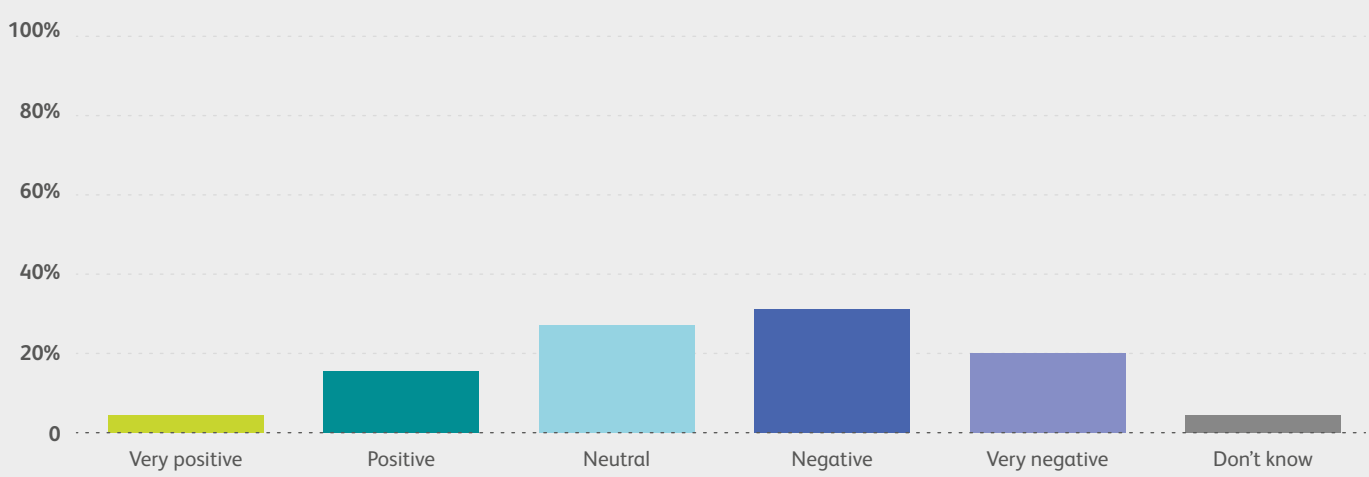
'We're working through the interplay of PCNs and the GP federations, and again looking to see what support we could put in place for PCNs. As I say, it's in its infancy – I don't want to scare PCN leaders too much because they've got a lot on,' explains Milligan.

Suffolk's Dr Garratt says: 'We're going to be looking at the membership of our ICS board in the coming months to ensure the PCN representation is reflected. The tricky thing is how you represent the PCNs, because I don't think you could have all 30-odd partners on the board. We are working out how they can be best represented, and how their voices can be heard.'

The survey reflects the nascent nature of these current relationships, leaning more towards the negative (see table below).

> **Locally, I think we have a good chance of influencing this. We have formed an alliance of all the county's PCN clinical directors, which gives us greater influence, and we have a supportive CCG.**

How do you feel about the representation of PCNs at ICS level?



Chapter 5 – The System: What is happening with the other structures in the NHS?

Clinical commissioning groups

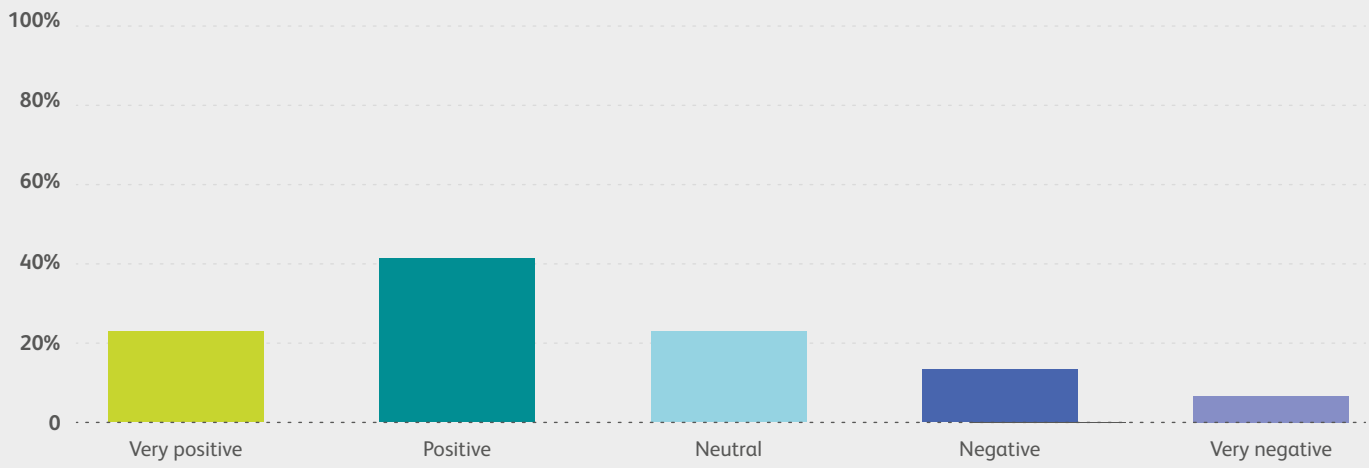
CCGs are currently responsible for commissioning planned hospital care, rehabilitative care, urgent and emergency care, out-of-hours care, community health services, mental health and learning disability services. They hold two-thirds of the NHS budget – £79.9bn in 2019/20.

NHS England is responsible for commissioning primary care services such as GPs in some areas, and dental services, as well as some specialised hospital services. Many GP services are now co-commissioned with CCGs. All GP practices are required to be members of their CCG.

But there has been a reduction in the number of CCGs – from 211 in 2013 to 135 now – and NHS England laid out two options in board papers in late November that could spell the end of CCGs. The first option would be 'one aligned CCG only per ICS footprint under this model, and new powers to allow CCGs to delegate many of [their] population health functions to providers'. The second proposed option would be for a 'statutory corporate NHS body model that brings CCG statutory functions into the ICS'. Under this model, ICSs would be established by 'repurposing CCGs' and would 'take on' CCGs' commissioning functions alongside other duties. The CCG governing body and GP membership model would be 'replaced' by a board, including representatives from NHS providers, primary care and local government, as well as executive roles 'as a minimum'.

> **"I am concerned that the primary care voice will not be loud enough.**

How do you feel about your CCG's support of the PCN in the first year?



Currently, though, PCNs continue to be mainly commissioned by CCGs. Some PCN leaders surveyed say there is micromanaging, but two-thirds (61%) say their CCG is supportive.

In Surrey Heartlands, relations between the CCG and PCN work well. Surrey Heartlands PCN clinical director Dr Pramit Patel is also the lead PCN clinical director for the Surrey Heartlands ICS. They use a WhatsApp group of clinical directors and commissioning managers to make sure there isn't an 'iron wall' between the two. Dr Patel says: 'When activity was really starting to rise at weekends through the digital front door, a couple of clinical directors wrote, "This is not sustainable. I can't do this." Our associate director of primary care picked it up straight away. And they switched it off. We've got a formal relationship, but it's a trusting relationship.'

> **"Our CCG has been very engaged, trying to be as supportive as possible.**

Newcastle's Dr Joughin also had words of praise for the CCG. 'Our CCG kindly had some money down the back of the sofa and paid us from January to April – they gave each clinical director a third session for four months,' she says. However, she expressed concerns that the PCNs were being pushed into transformation work.

'The other problem is, there's that huge ask; you've got your own network needs, but in most cities and most CCG areas, they are using the PCN clinical directors to come into city-wide work and transformation work. Which is good, and yes we want community and primary care to be involved in that, but again that's another big ask,' explains Dr Joughin.

Federations

There is a more complex picture emerging as to how PCNs fit in with pre-existing GP collaborations. For the primary care homes sites, evolving into a PCN seems straightforward, but other collaborations gel less well with the new vision.

The PCN leaders interviewed had varying agreements with their federations. These are grassroots organisations where GP practices club together to spread the risk and responsibility of providing services across their community. A PCN is aimed to be a broader collaboration of practices and other health and care partners.

NHS England does not intend PCNs and federations to be mutually exclusive. They can co-exist to deliver a broader set of integrated out-of-hospital services for their local communities. Some federations act as umbrella organisations to PCNs, taking on some of the risk and function to free up the PCNs.

Doncaster's Dr Kumar explains: 'We asked [the local federation] to hold the contract in such a way that part of the managerial role is taken away from the PCNs and they hold the contract. They work with the practices and the practice managers, but nevertheless the money goes to them and they distribute the wages.'

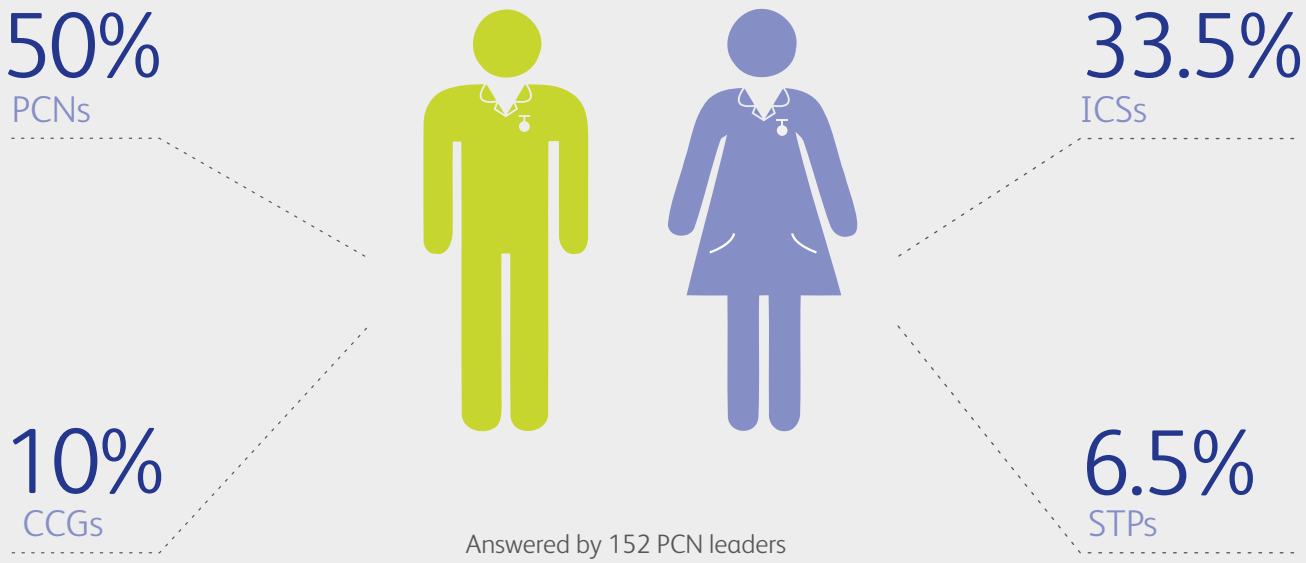
Dr Agrawal says that in Cannock, the federation offered to look after the four PCNs' HR and accounting, which all of the member practices agreed to. However, during the first six months it became difficult to synchronise what the different PCNs wanted. 'It didn't go as well as we thought,' says Dr Agrawal. 'We found there were personal rifts between PCNs, making it really difficult to manage and affecting the other PCNs negatively. We made a decision that it would be better for the PCNs to perform on their own. I think it was always going to happen – you can't have 22 surgeries all working harmoniously with each other.' He adds that if PCNs do carry out all their own work, it will spell the end of federations.

The interplay between the various manifestations of GP groups and PCNs will take some time to be worked through, and it seems as if they will initially create complex ways of working.

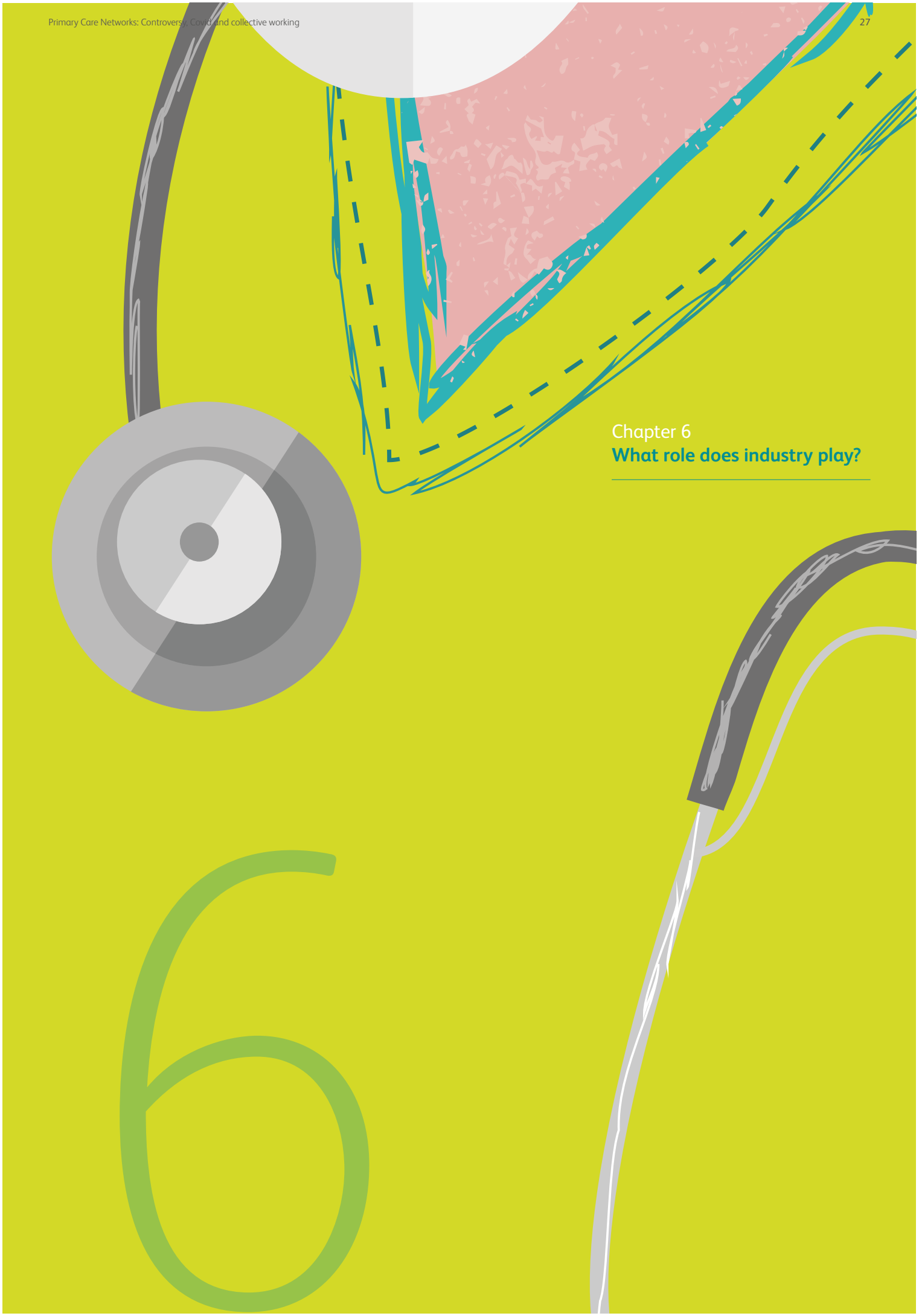
Key points:

- PCNs are part of a number of organisational changes within the NHS, including the establishment of integrated care systems (ICSs), a change in the role of CCGs and the ongoing upscaling of general practice.
- By April 2021, ICSs are expected to cover the whole of England, bringing together healthcare commissioners, providers and local authorities, with the aim of giving them greater freedom to manage the operational and financial performance of services.
- CCGs – seen as the major commissioners of healthcare services when introduced in 2013 – are reducing in number, from 212 in 2013 to around 140 today.
- There is a more complex picture emerging as to how PCNs fit in with pre-existing GP collaborations such as federations. It may take a while to find the optimal way of working.

Which organisation do you feel will be most important over the next five years?



Answered by 152 PCN leaders



Chapter 6

What role does industry play?

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With PCNs formed in July 2019, NHS England has developed a new model to bring health and social care providers together to deliver preventative and personalised care for the local population, to encourage collaborative working in the NHS and to give GPs more power.

PCNs are still in the process of development and have yet to reach an optimal way of working. Despite this, and still being very much in their infancy, PCN clinical directors are already seeing benefits to a PCN. These observed benefits include a framework and platform for neighbouring practices to operate in and set up their own PCNs.

The current pandemic brought the benefits of a collaborative PCN to the fore. The benefits and opportunities that came from working collaboratively – as one PCN in place of several independent GP practices – were brought to the attention of primary care leads. This will pave the way for a more scalable way of working.

PCNs are expected to become increasingly vital over the next five years compared with CCGs, ICSs and STPs, so establishing good, collaborative working relationships with them is crucial. Owing to the nature of the PCN, it is expected that future business in primary care will take place via a PCN, replacing single GP practices. The focus will be on prevention and early intervention, planned care for people with long-term conditions, and reducing the pressure on emergency and hospital care. However, there is still some uncertainty about how industry can best support PCNs as a new NHS customer to improve local care.

> **“Working in a digital way meant we got much greater reach in terms of being able to get two-way communications set up.**

The 5 steps to scalable working

Know

With the current global situation, and as is expected when any change to organisational structure occurs, staying informed and up to date with the marketing needs of a strategic partner is of paramount importance. To engage effectively with PCNs, sales teams may benefit from additional training on the when, why and how to reach out to primary care leads.

Engage

Primary care leads now have more responsibility, but even less time; therefore, they need to be engaged as efficiently and effectively as possible. Now more than ever, reaching out to the right person at the right time with a tailored and bespoke message is increasingly important.

Educate

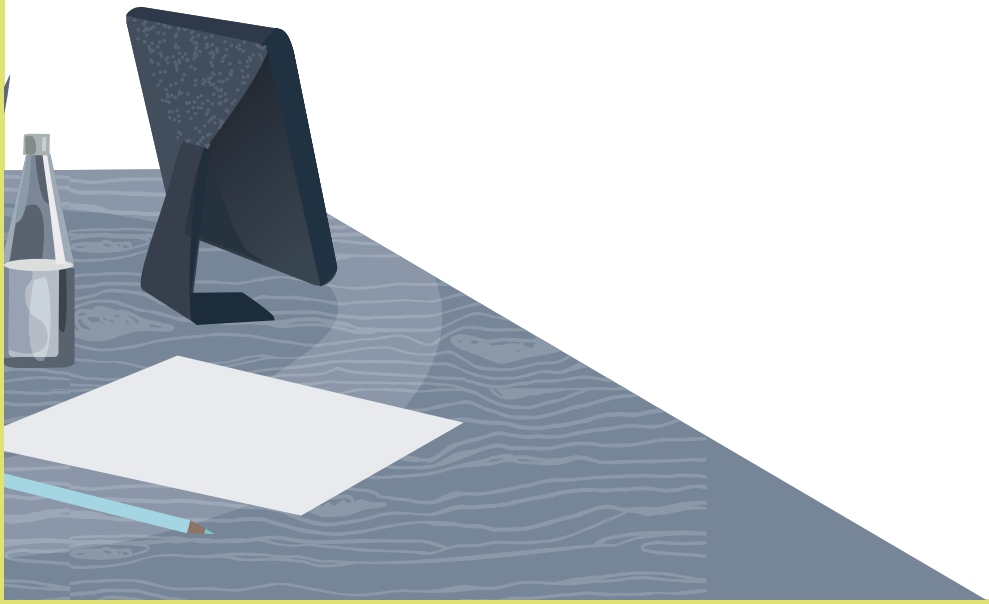
With the additional roles reimbursement scheme not appearing to be adequate and flexible enough yet, there exists an educational need for primary care practitioners who are already in the field. It is important to know what formats work and how to engage primary care practitioners in peer-to-peer education, especially during the pandemic, where face-to-face training has made way for virtual education, providing industry with the opportunity of reaching out to a larger and a more multidisciplinary audience.

Support

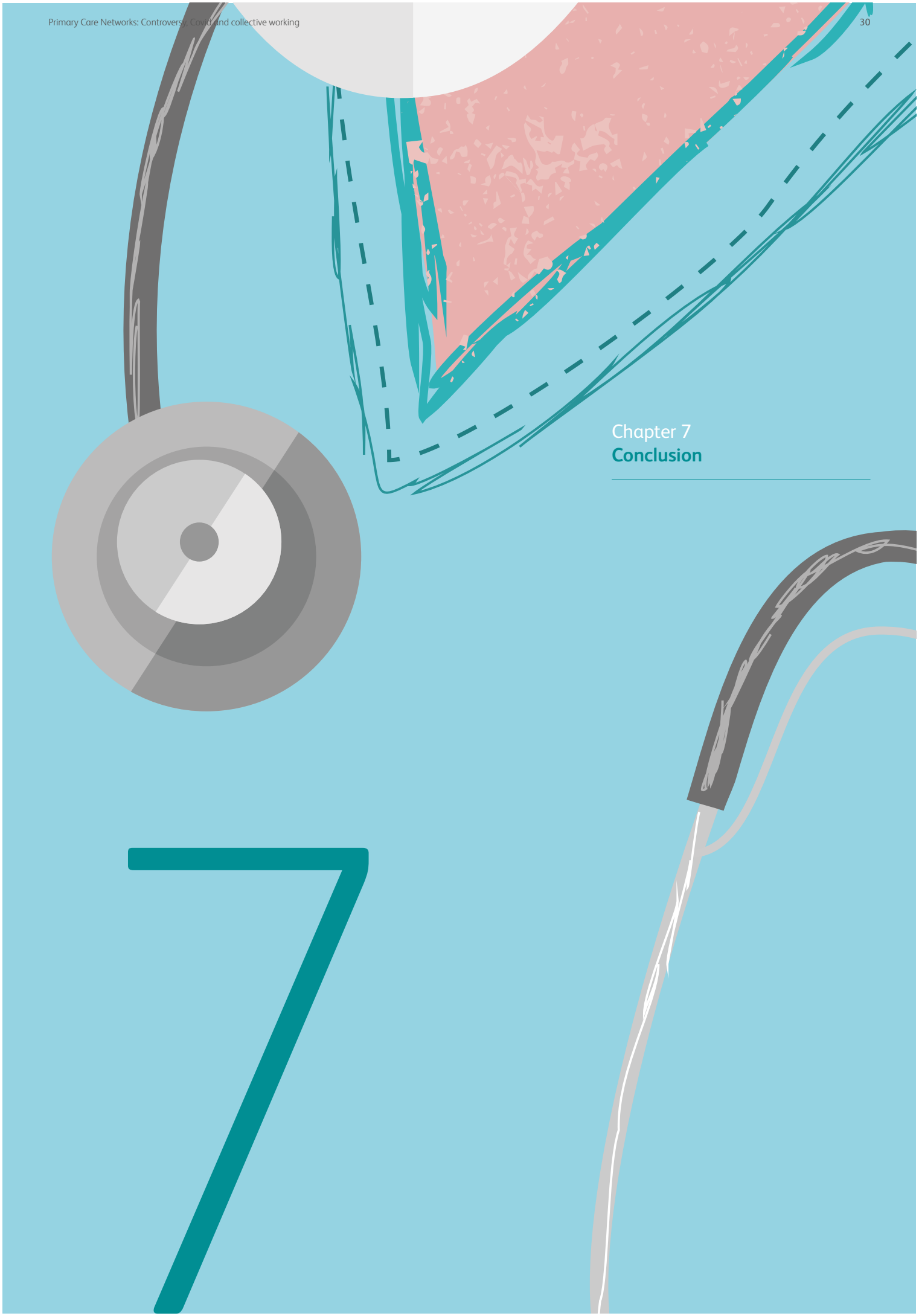
Supporting primary care through strategic partnerships can lead to financial barriers being removed, or fulfilling roles under the Network DES additional roles reimbursement scheme. As there is no better source for insights into primary care than the PCN itself, supporting PCNs in this way results in first-hand information in how to improve local care.

Evaluate

Where PCNs are considered the heart of primary care, an end-to-end solution saves time, money and energy for the primary care practitioner and improves efficiency. As with every process, evaluating what worked and what did not will kickstart the following cycle. Accumulating insights from every stage, reporting and reviewing the strategic partnership with PCNs are the cornerstones for a successful relationship with primary care.



> **“The ability to operate primary care at scale has been fantastic.**



Chapter 7

Conclusion

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Chapter 7

Conclusion

While most agree that the concept of PCNs is the right one to pursue, work still needs to be done on the execution.

The requirements set out in the Network DES, particularly around ARRS, are considered too prescriptive by many of the survey respondents and those interviewed.

The costing around payments for the clinical director and the management costs of running the PCN need to be looked at again.

There is no doubt that leading GPs in the PCNs give their free time to support this endeavour, but that is likely to be time-limited without another look at the funding and support for the role.

The real cost of recruiting, paying and training of health professionals through the ARRS will also need to be looked at again. The ARRS scheme is generally welcomed. However, the concern is that instead of freeing up and empowering general practice with a raft of multidisciplinary health and care professionals, it has landed them with extra work, burdening practices with an isolated, 'un-housed' workforce and a cascade of new responsibilities.

In areas where a primary care home was established, it was a small step to move to the PCN model. However, those areas where there was no pre-existing structure are behind the curve. They need the time and the space to develop.

Trust between PCNs and the wider healthcare system needs to be nurtured.

PCNs need to feel supported by the wider structures, represented at ICS level and not overly managed by CCGs.

The relationships between PCNs and other GP provider groups and federations need to be worked out, and practices within PCNs must be able to work together.

There is no doubt that PCNs create the space for a unified, powerful, provider voice, but it will take time to work through the change and establish them as an integral part of the primary care landscape.

There is a will to ensure the PCN voice is heard at the top table of the NHS systems.

Possible future legislation to remove barriers and create a more integrated health and care system is expected next year.

Their introduction could not have been more timely given this year's Covid-19 pandemic. All those interviewed agree that the relationships and arrangements set up through the PCNs enable an agility and a resilience in coping with the demands of the pandemic. The vaccination programme will prove a real test of this agility and resilience.

It is hoped that the teething issues highlighted here can be addressed by NHS England, and that PCNs live up to their undoubted potential.

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