Primary Care Networks: sharing learning from local areas

Thursday 21 February, 12pm-1.30pm

Aims of the webinar

This engagement webinar aims to:

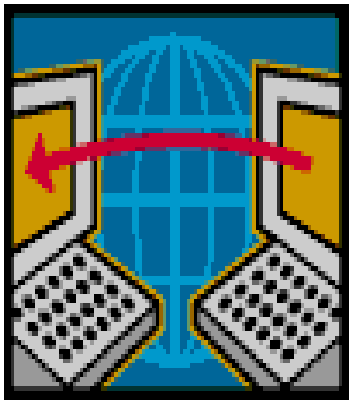
- Provide an update on the primary care networks programme.
- Provide examples of the some of the positive impacts for patients and staff.
- Consider what support may be needed in the journey to PCNs and how this could be delivered at a national, regional and local level.

Things are changing…

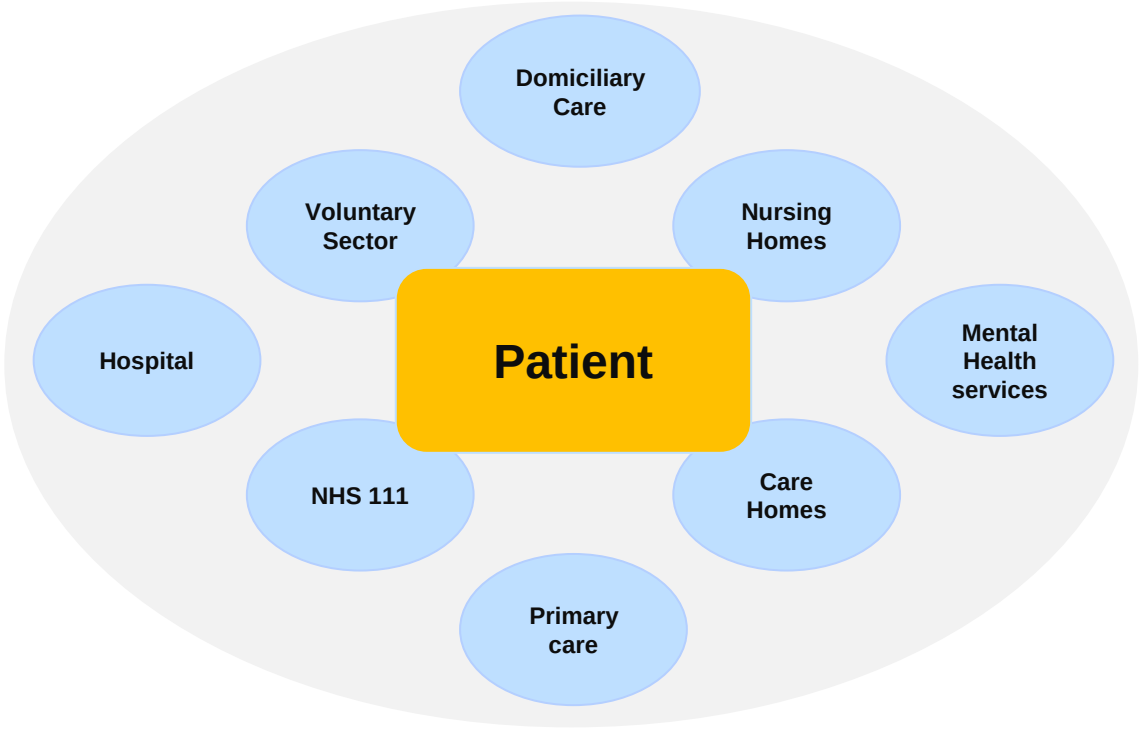
The changing health needs of the population are putting pressure on the health and social care system in England.

Ageing population	Between 2017 and 2027, there will be 2 million more people aged over 75.
Chronic conditions	The main task has changed from treating individual episodes of illness, to helping people manage long-term conditions.
New Treatments	The steady expansion of new treatments gives rise to demand for an increasing range of services.

And our expectations are changing too.



… and the system has not changed enough to meet our needs



- Service provision is fragmented in multiple different types of organisations
- Too often, these services don't communicate effectively with each other
- The totality of patients' needs are not always understood by those serving them
- Care is not always delivered in a person-centred way

Despite growing pressures, the NHS is efficient, equitable, and improving

NHS England

The system operates under considerable pressure

- Helps over 20 million mental health service users a year[1]
- Conducts 5 million GP consultations per week[2]
- Serves over 1 million patients[3], delivers 1,900 babies[4], admits 64,000 people to A&E[1], completes 28,000 operations a day[1]

We continue to improve in specific areas

- Waiting times are lower than a decade ago (although slowly rising)[7]
- Annual cancer survival rates are improving[8]
- Heart attack and stroke deaths have tumbled (total CVD mortality is down 68% since 1980)[7]

The NHS is more efficient that the rest of the economy

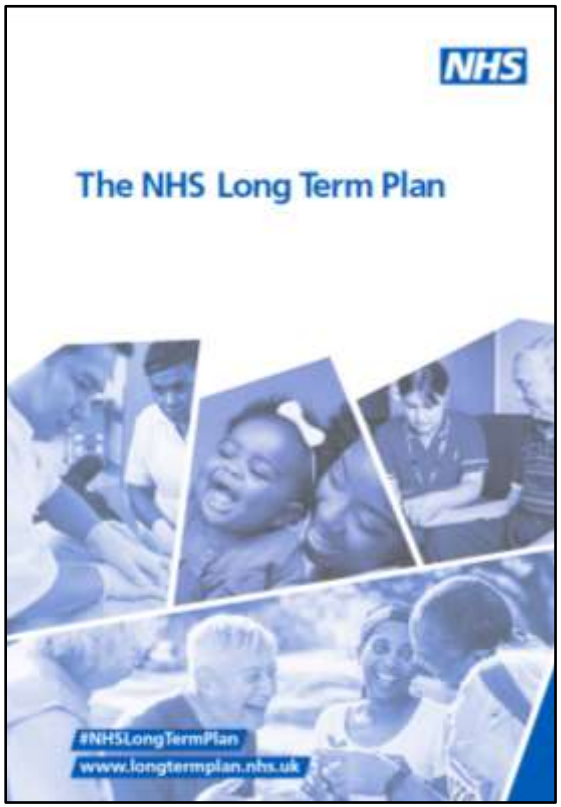
- In 2016-17 healthcare productivity grew by 3.0%, more than treble the rate achieved across the wider UK economy

However, we still lag behind our international counterparts in some areas

Above average performance	Below average performance, but improving	Below average performance
Diabetes	Breast cancer	COPD
Kidney disease	Colorectal cancer	Heart attack
Suicide	Lung cancer	Amenable mortality
Patient experience	Pancreatic cancer	Birth
	Stroke	
	Lower respiratory tract infection	

Source: Nuffield Trust Report – How Good is the NHS? (2018)

The NHS Long Term Plan



Aims:

- Everyone gets the best start in life
- World class care for major health problems
- Supporting people to age well

How:

- Developing integrated care systems with primary care networks as the foundation
- Preventing ill health and tackling health inequalities
- Supporting the workforce
- Maximising opportunities presented by data and technology
- Continued focus on efficiency

The NHS Long Term Plan – Funding and Support

- **£4.5bn of new investment.**

- This new investment will enable PCNs to attract and fund additional staff to form an integral part of an expanded multidisciplinary team.

- Initially this will focus on clinical pharmacists, link workers, physiotherapists and physician associates. Over time, it will be expanded to include additional groups such as community paramedics.

- The Government has also committed to a new state-backed GP indemnity scheme from April 2019.

The NHS Long Term Plan - Workforce

- Building on the General Practice Forward View (GPFV) commitment to increase the number of doctors working in general practice - continued commitment to the increase of 5,000 doctors.

- In addition, there will be a continued focus for a range of other roles – pharmacists, counsellors, physiotherapists, nurse practitioners.

- Expanded neighbourhood teams including GPs, nurses, pharmacists, community geriatricians, dementia workers and AHPs plus social care and the voluntary sector.

- Newly qualified doctors and nurses entering general practice will be offered a two-year fellowship.

- Training and development of multi-disciplinary teams in primary and community hubs.

- Through social prescribing the range of support available to people will widen, diversify and become accessible across the country. Link workers with PCNs will work with people to develop tailored plans and connect them to local groups and support services.

The NHS Long Term Plan - Digital

- A digital NHS ‘front door’ through the NHS App will provide advice, check symptoms and connect people with healthcare professionals.

- Digital first primary care will become a new option for every patient improving fast access to convenient primary care. Over the next five years every patient in England will have a new right to choose this option – usually from their practice, or if they prefer, from one of the new digital GP providers.

- We will do this by:
  - Creating a new framework for digital suppliers to offer their platforms to PCNs on standard NHS terms.

- In parallel we will ensure that new ‘digital first’ practices are safe and create benefit to the whole NHS. This means reviewing current arrangements including out-of-area arrangements.

- Reviewing GP regulation and terms and conditions to better support the return to practice and increased participation rates by GPs wanting to work in this way.

The NHS Long Term Plan in summary

NHS England

1. Do things **differently, through a new service model**
2. Take more action on **prevention** and **health inequalities**
3. Improve **care quality and outcomes** for major conditions
4. Ensure that **NHS staff** get the backing that they need
5. Make better use of **data** and **digital technology**
6. Ensure we get the most out of **taxpayers' investment** in the NHS

How will the LTP support delivery of networks?

Service Integration

- Community service redesign into clinical networks 30-50K with an accountable clinical director for each PCN
- Community multi-professional teams, responsive and proactive
- Expansion of community MDTs to operate in networks of practices, funding through a network contract
- Fully integrated community based health care , training locally, community hospital hubs
- Enhanced health in care homes
- Direct booking to 111

Financial

- 4.5billion over five years
- Contracting may be at PCN level for some services
- Need to develop the provider landscape
- Should develop local clinical leadership- Network clinical directors
- Accountability
- Shared saving scheme, links to emergency avoidance
- Review of QOF
- £1.50 per head recurrent funding

Prioritisation

- Focus on outcomes, less on targets
- Use Population Health Management – tools, data, intelligent decision making, create the right architecture to support this
- Prevention – stronger immunisation
- Personalised care plans
- Increase social prescribing
- Focus on children and young people, safer maternity services, and mental health – addressing unmet need
- Early detection cancers

Governance & Leadership

- Clear line of sight from primary care to ICS exec team
- Accountability
- Local ownership
- Focus on outcomes
- Dedicated time for clinical leaders
- Clear career progression

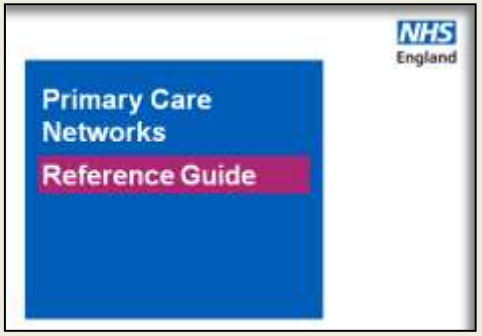
Digital front end and technology

- Sharing records
- Population Health focus
- Home based and wearable monitoring (tech)
- Improved urgent care as a system, clinical assessment service
- Digital first access to primary care

Background

A working definition

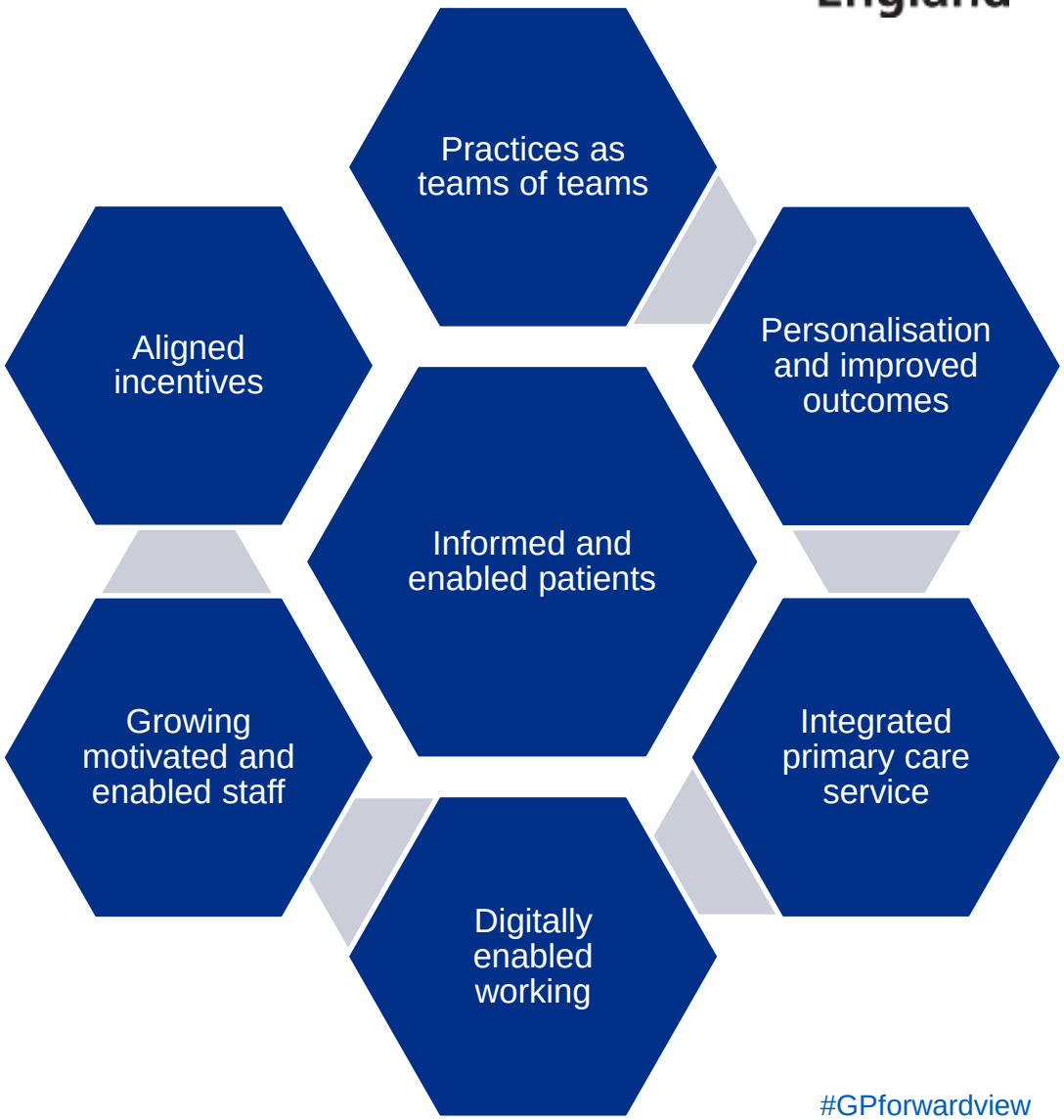
Primary care networks enable the provision of **proactive, accessible, coordinated and more integrated primary and community care** improving outcomes for patients. They are likely to be formed around natural communities based on GP registered lists, often serving **populations of around 30,000 to 50,000**. Networks will be small enough to still provide the personal care valued by both patients and GPs, but large enough to have impact through deeper **collaboration between practices and others in the local health (community and primary care) and social care system**. They will provide a platform for providers of care being sustainable into the longer term.



- Provides support for local communities, building on learning from the existing models;
- Provides advice on the key areas commissioners and practices might consider in establishing primary care networks locally;
- Sets out the vision for networks, core characteristics, care models at the heart of primary care at scale;
- Identifies key enablers that underpin effective development of networks;
- Shared widely for comments and we'd like your views – released in autumn.

Primary care networks – key to the future

- Primary care networks are small enough to give a sense of local ownership, but big enough to have impact across a 30-50K population.
- They will comprise groupings of clinicians and wider staff sharing a vision for how to improve the care of their population and will serve as service delivery units and a unifying platform across the country.



#GPforwardview

The evidence base for the PCN population size:

Networks in action

National Association of Primary Care (2015). Primary Care Home: An Overview

Dunbar R (2010). How many friends does one person need? London: Faber and Faber

Ham C (2010). GP budget holding: Lessons from across the pond and from the NHS University of Birmingham HSM

Martin S, Rice N, Smith P (1997) Risk and the GP Budget Holder York: Centre for Health Economics

Bachmann M, Bevan G (1996) Determining the size of a total purchasing site to manage financial risks of rare costly referrals: computer simulation model British Medical Journal

ZIO network, Maastricht, the Netherlands

‘15% decrease in proportion of patients with poor glycaemic control’

Lakes district health board, Midlands Health Network, NZ

‘…a history based around quality improvement and the sustainability of the GP-patient relationship’

Primary Care Networks, Alberta, Canada

‘The Quality Council of Alberta research confirms that patients attached to a Primary Care Network (PCN) showed decreased use of acute care services’

The role of continuity - small enough to care, big enough to cope:

How can we get better at providing patient centred care: does continuity matter?

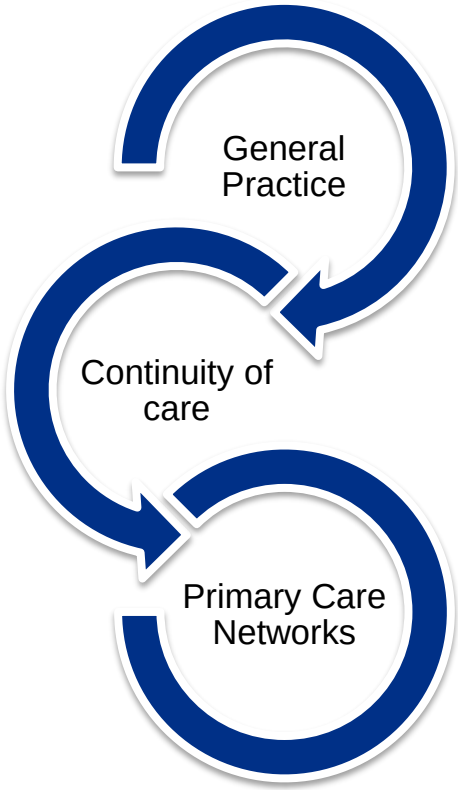
https://www.bmj.com/content/350/bmj.h1127/rr

Divided we fall: getting the best out of general practice

https://www.nuffieldtrust.org.uk/research/divided-we-fall-getting-the-best-out-of-general-practice

Personalising care for patient sub-groups in general practice

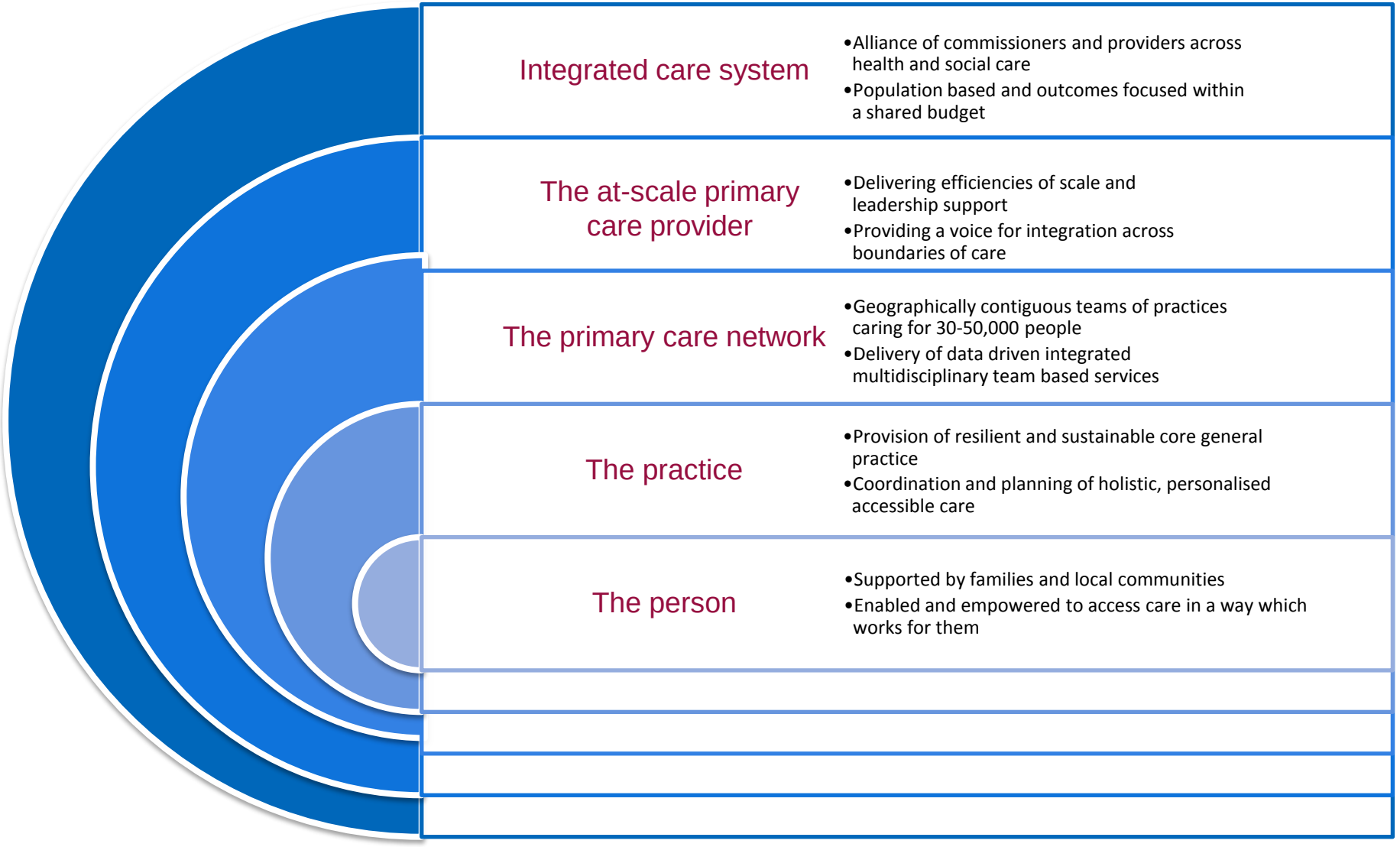
https://www.health.org.uk/programmes/innovating-improvement/projects/segmenting-within-general-practice-personalising-care



"With enough funding and staffing it should be possible to offer every patient both timely, convenient access for immediate problems and a continuous relationship with one or more clinicians for those with more complex ongoing needs."

THE MODEL OF CARE

NHS England



Integrated care system	•Alliance of commissioners and providers across health and social care •Population based and outcomes focused within a shared budget
The at-scale primary care provider	•Delivering efficiencies of scale and leadership support •Providing a voice for integration across boundaries of care
The primary care network	•Geographically contiguous teams of practices caring for 30-50,000 people •Delivery of data driven integrated multidisciplinary team based services
The practice	•Provision of resilient and sustainable core general practice •Coordination and planning of holistic, personalised accessible care
The person	•Supported by families and local communities •Enabled and empowered to access care in a way which works for them

Primary care networks: where are we?

Many practices are already part of a network:

As at 30 November 2018 (**) Note: 15 CCGs are missing from this report	Registered Population	Registered Population (excluding CCGs that did not submit a return)	Number of practices	Number of practices (excluding CCGs that did not submit a return)	Number of practices which are part of a network	% of practices which are part of a network	Number of Primary Care Networks currently existing
EN	59,483,315	55,749,714	7,039	6,424	5,998	93.4%	953
North	16,448,930	13,399,622	2,143	1,661	1,461	88.0%	260
Midlands and East	17,955,024	17,955,024	2,080	2,080	1,960	94.2%	300
London	9,975,083	9,290,790	1,286	1,153	1,117	96.9%	105
South West	5,805,507	5,805,507	604	604	554	91.7%	99
South East	9,298,771	9,298,771	926	926	906	97.8%	189

Source: GPFV monitoring survey

So we are building from a good position, but we need to support this important development in the NHS…

What great PCNs look like and how they will develop

	Foundations for transformation	*Step 1*	*Step 2*	*Step 3*
Right scale	**Plan:** There is a plan in place articulating a clear end state vision and steps to getting there, including actions required at team, network and system level	**Practices** identify partners for network-level working and develop shared plan for realisation.	**Practices** have defined future business model and have early components in place. Functioning **interoperability between practices,** including read/write access to records. Data sharing agreements in place.	**Network business model** fully operational. **Interoperable systems** Workforce shared across network. Rationalisation of estates.
Integrated working	**Engagement:** GPs, local primary care leaders and other stakeholders believe in the vision and the plan to get there.	**Integrated teams**, which may not yet include social care, are working in parts of the system.	**Integrated teams** in place throughout system and formalised to include social care, the voluntary sector and easy access to secondary care expertise in at least some sites.	**Fully functioning integrated teams** in place across whole system including general practice, access to secondary expertise, nursing, community services, social care and voluntary sector. Care plans and coordination in place for all high risk patients.
Targeting care	**Time:** Primary care, in particular general practice, has the headroom to make change.	**Analysis on variation** between practices is readily available and acted upon. **Basic population segmentation** is in place, with understanding of needs of key groups and their resource use. Standardised end state **models of care** defined for all population groups, with clear gap analysis to achieve them. **Prototypes** in place for highest risk groups.	The system can **track data in real time,** including visibility of patient movement across the system and between segments, and information on variability. **New models of care** in place for most population segments, including both proactive and reactive models, with standardised protocols in use across the system.	**Systematic population segmentation including risk stratification**, with in depth under-standing of needs of each population segment. Routine peer review of metrics in and between networks. **New models of care in place to meet needs of all population segments**. Internal referral processes in place.
Managing resources	**Transformation resource:** There are people available with the right skills to make change happen.	Steps taken to ensure **operational efficiency** of primary care delivery.	**Networks have sight of resource use** for their patients, and can pilot new incentive schemes.	Primary care networks take **collective responsibility for available funding.** Data being used at individual clinical level to make best use of resources.
Empowered Primary Care		**Primary care** has a seat at the table for all system-level decision making.		**Primary care network** full decision making member of ICS leadership.

How to keep in touch

- NHS England has developed an animation to help explain what a PCN is. You can watch the animation and view dates and details of upcoming webinars and events at the following webpage: www.england.nhs.uk/pcn

- We have also set up a Future NHS platform to share slides and documents which you can request access to via our generic email address: england.PCN@nhs.net

- For any other queries, please email the team at england.PCN@nhs.net

Bev Taylor,
NHS England

Personalised care and social prescribing in the NHS Long Term Plan

Long-term plan: 5 major practical changes to the service model

1. We will **boost 'out-of-hospital' care**, and finally dissolve the historic divide between primary and community health services.
2. The NHS will **redesign and reduce pressure on emergency hospital services.**
3. **People will get more control over their own health, and more personalised care when they need it.**
4. **Digitally-enabled primary and outpatient care** will go mainstream across the NHS.
5. Local NHS organisations will increasingly **focus on population health** and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.

The NHS Long Term Plan

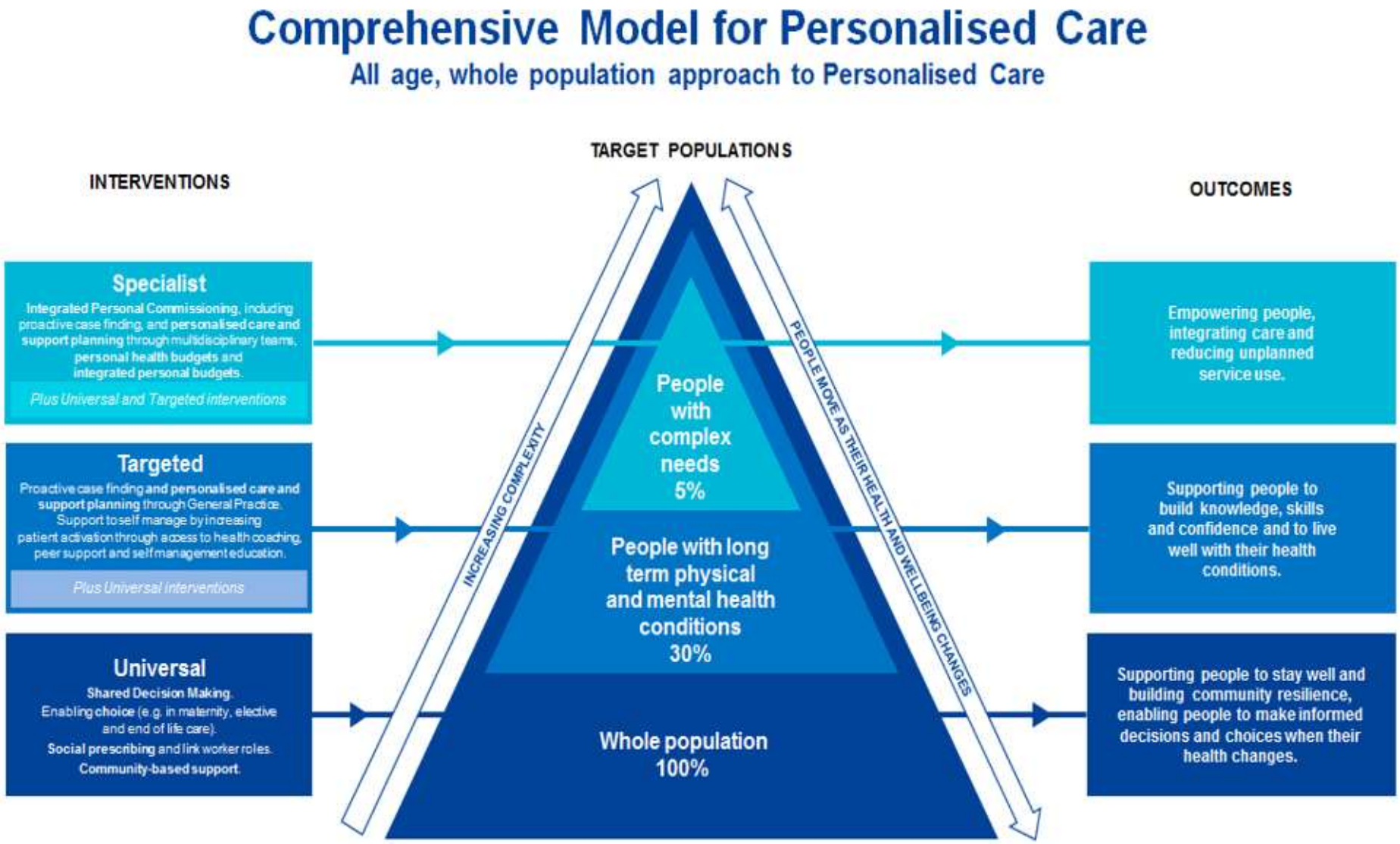
#NHSLongTermPlan / www.longtermplan.nhs.uk

Long Term Plan commitments

- 1.39. **We will roll out the NHS Personalised Care model across the country, reaching 2.5 million people by 2023/24 and then aiming to double that again within a decade**.

- 1.40. As part of this work, through **social prescribing** the range of support available to people will widen, diversify and become accessible across the country. Link workers within primary care networks will work with people to develop tailored plans and connect them to local groups and support services. **Over 1,000 trained social prescribing link workers will be in place by the end of 2020/21** rising further by **2023/24,** with the aim that **over 900,000 people** are able to be referred to social prescribing schemes by then.

This means a, comprehensive whole population approach:



Personalised Care Operating Model

WHOLE POPULATION
when someone's health status changes

30% OF POPULATION
People with long term physical and mental health conditions

Cohorts proactively identified on basis of local priorities and needs

Shared Decision Making
People are supported to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action, based on their personal preferences and, where relevant, utilising legal rights to choice (All tiers)

Personalised Care and Support Planning
People have proactive, personalised conversations which focus on what matters to them, delivered through a six-stage process and paying attention to their clinical needs as well as their wider health and wellbeing.

Review
A key aspect of the personalised care and support planning cycle. Check what is working and not working and adjust the plan (and budget where applicable)

LEADERSHIP, CO-PRODUCTION AND CHANGE ENABLER

COMMISSIONING, CONTRACTING AND FINANCE ENABLER

WORKFORCE ENABLER

DIGITAL ENABLER

Optimal Medical Pathway

Social Prescribing and Community-Based Support
Connect people to community-based approaches to make the most of community and informal support by enabling professionals to refer people to a 'link worker', based on what matters to the person (All tiers)

Supported Self Management
Support people to develop the knowledge, skills and confidence (patient activation) to manage their health and wellbeing through interventions such as health coaching, peer support and self-management education (Targeted and Specialist)

Personal Health Budgets and Integrated Personal Budgets
An amount of money to support a person's identified health and wellbeing needs, planned and agreed between them and their local CCG. May lead to integrated personal budgets for those with both health and social care needs (Initially Specialist)

Five Year Framework for GP Contract Reform

- NHS England will provide funding directly to primary care networks for a new, **additional social prescribing link worker to be embedded within every primary care network multi-disciplinary team**, through the Network Contract Direct Enhanced Service (DES).
- Starting from July 2019, at **100% reimbursement** of the actual on-going salary costs, up to a maximum amount (£34,113) GP Contract Reform, section 1.26. The percentage will neither taper nor increase during the next **five years**, giving networks maximum confidence to recruit to the full.
- Existing practice suggests that many primary care networks may **choose to fund a local voluntary sector organisation to employ the link workers on behalf of the network**. The contractual arrangement will be for local areas to decide, but the funding will be routed via the Network Contract DES.
- Funding will also be available to **all primary care networks** across England, including local areas where link workers are already embedded in primary care multi-disciplinary teams.

Key elements of social prescribing in Primary Care Networks

Link workers in Primary Care Networks

Social prescribing link workers will be **embedded within primary care network multi-disciplinary teams** to;

- provide **personalised support to individuals, their families and carers** to take control of their wellbeing, live independently, and improve their health outcomes
- develop trusting relationships by giving people time and focusing on '**what matters** to them'
- take a **holistic approach**, based on the person's priorities, and the wider determinants of health
- co-produce a simple personalised care and **support plan** to improve health and wellbeing
- introduce or reconnect people to **community groups and services**
- evaluate the individual impact of a **person's wellness progress**
- record referrals within GP clinical systems using the national **SNOMED** social prescribing codes
- support the delivery of the comprehensive model of **personalised care**
- draw on and increase the **strengths and capacities of local communities**, enabling local VCSE organisations and community groups to receive social prescribing referrals.

How can local partners maximise this funding opportunity?

CCGs will be encouraged to bring local partners together to **develop a shared local plan for social prescribing (by June 19)**, including local authorities, primary care networks, VCSE leaders, existing social prescribing connector schemes and other partners. Plans should include:

- How partners will **build on existing local social prescribing** connector schemes to avoid duplication and maximise impact
- How social prescribing link workers will be embedded in all **primary care networks** across the local area
- How additional link workers will be **recruited locally**
- Shared commitment to **support for the VCSE sector and community groups** to receive social prescribing referrals, through funding and development support.

Templates are available from NHS England: england.socialprescribing@nhs.net

NHS England publications:

- Summary Guide to Social Prescribing
- Universal Personalised Care
- NHS Long Term Plan
- Five Year Framework for GP Contract Reform
- NHS England has set up an online learning platform to share the latest resources. To join the platform, please contact england.socialprescribing@nhs.net

NHS England

Dr Mark Spencer
GP, Fleetwood

NHS England

http://napc.co.uk/primary-care-home/

NHS England

Thank you

For a copy of the slides, please email: england.pcn@nhs.net
Visit www.england.nhs.uk/pcn for more information