What is a Primary Care Network?

British Geriatric Society

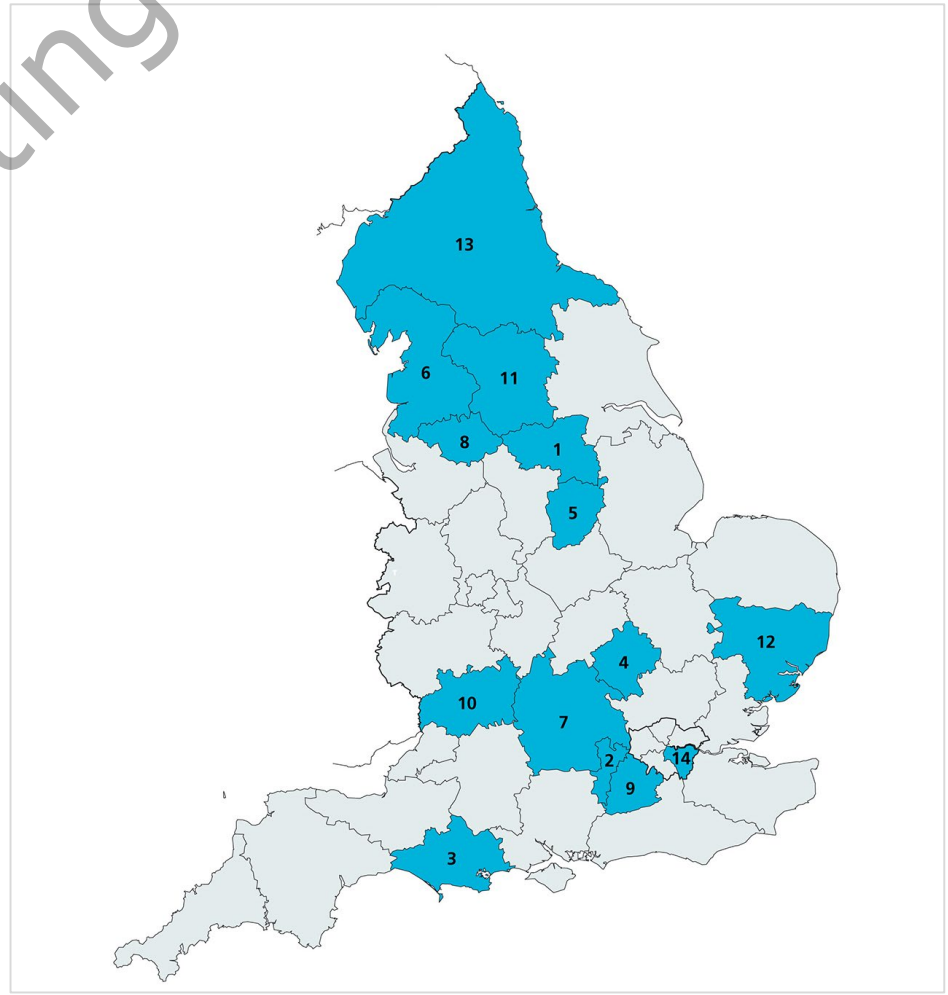
BGS Autumn Meeting 2019

Dr Karen Kirkham

NHS England and NHS Improvement

Systems working together to become more integrated

- Since 2016, health and care organisations have been working together in every part of England in sustainability and transformation partnerships (STPs).
- Local councils, care homes and different parts of the NHS – hospitals, family doctors, mental health teams and others – are working together more closely than ever before. In partnerships covering every part of England, they have begun to coordinate services better, spend more on keeping people healthy and out of hospital, and agree shared priorities for the future
- In ICSs, more formally organised STPs, NHS organisations take collective responsibility for managing shared resources and using them to improve quality of care and health outcomes for local residents, working closely with local councils and others in the community.
- The first of these systems were confirmed in 2018, with more announced in June this year. They now serve one in three people in England (21 million).
- Each has shown that its partners all share a common vision to improve health and care, backed up by robust operational and financial plans, and proposals for collective leadership and accountability.



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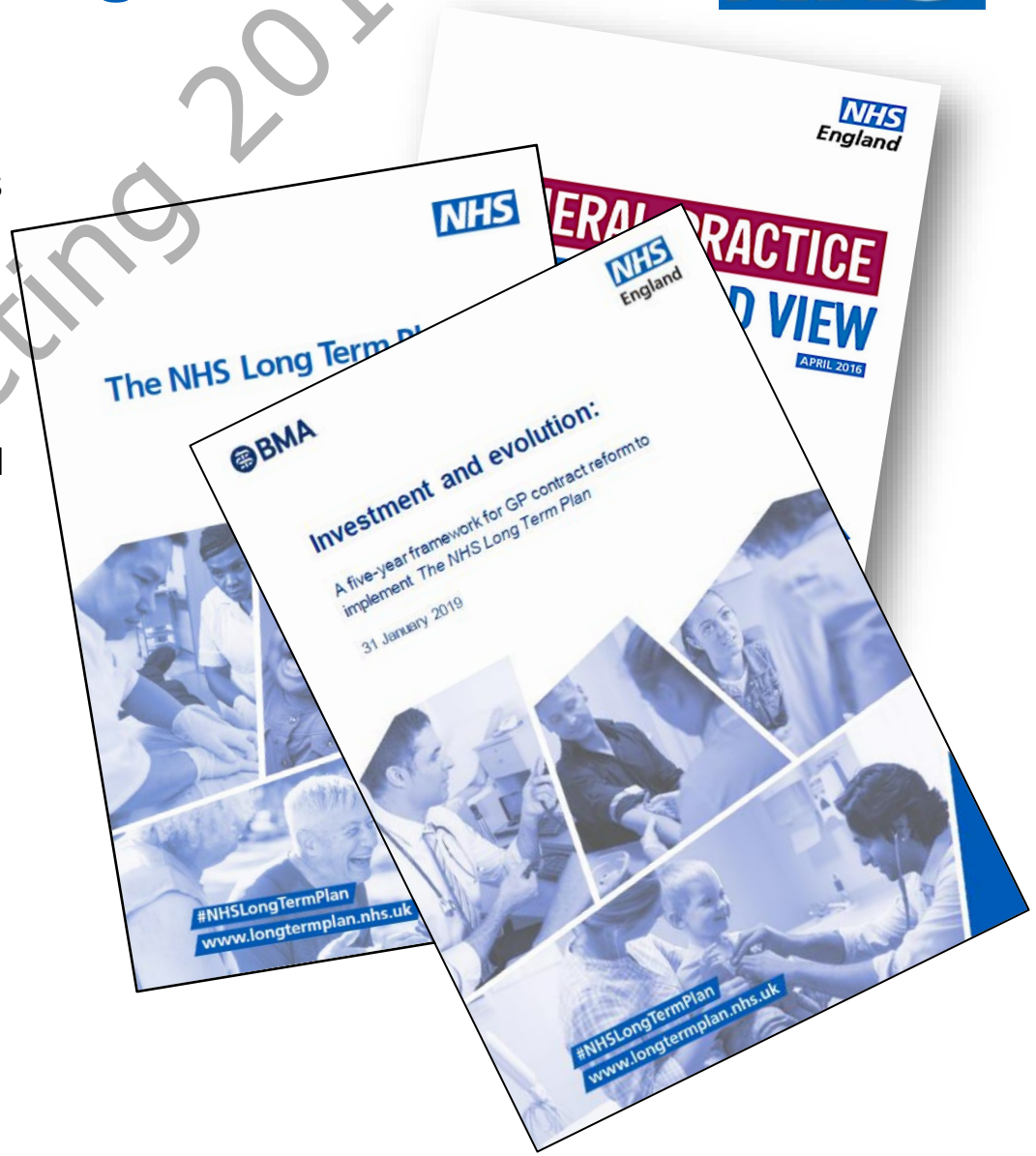
Primary care at the heart of the NHS Long Term Plan…

- The NHS Long Term Plan outlined the ambition for Integrated Care Systems (ICSs) to cover the whole country by April 2021.
- **Primary care networks** (PCNs) will be the **building block of every ICS,** working with other partners to deliver out of hospital care.
- Alongside this, we will create "**genuinely integrated teams of GPs, community health and social care staff**…fully integrated community-based health care" to "finally **dissolve the historic divide between primary and community health services**"
- "**spending…will be at least £4.5 billion higher in five year's time**"

Why change?

- Staff
- Patient needs
- Systems



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What are we trying to achieve?

- **Seamless care (for both physical and mental health) across primary care and NHS community services**, and remove the historic separation of these parts of the NHS
- **Care as close to home as possible**, with networks and services based on natural geographies, population distribution and need rather than organisational boundaries
- **Integration across primary care networks and secondary care/place-based care** with more clinically-appropriate secondary care in primary care settings
- Assessment of population health - **focusing on prevention and anticipatory care** - and maximise the difference we can make operating in partnership with other agencies
- Promote and **support people to care for themselves** wherever appropriate
- **Build from what people know about their patients and their population**
- Make a **tangible difference for patients and staff alike,** with:
  - improved outcomes for patients and an integrated care experience for patients;
  - more sustainable and satisfying roles for staff, and development of multi-professional teams; and
  - a more balanced workload for all.

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What do we mean by primary care networks?

A primary care network consists of **groups of general practices working together with a range of local providers**, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations.

Networks would normally be **based around natural local communities typically serving populations of at least 30,000 and not tending to exceed 50,000**. They should be small enough to maintain the traditional strengths of general practice but at the same time large enough to provide resilience and support the development of integrated teams.

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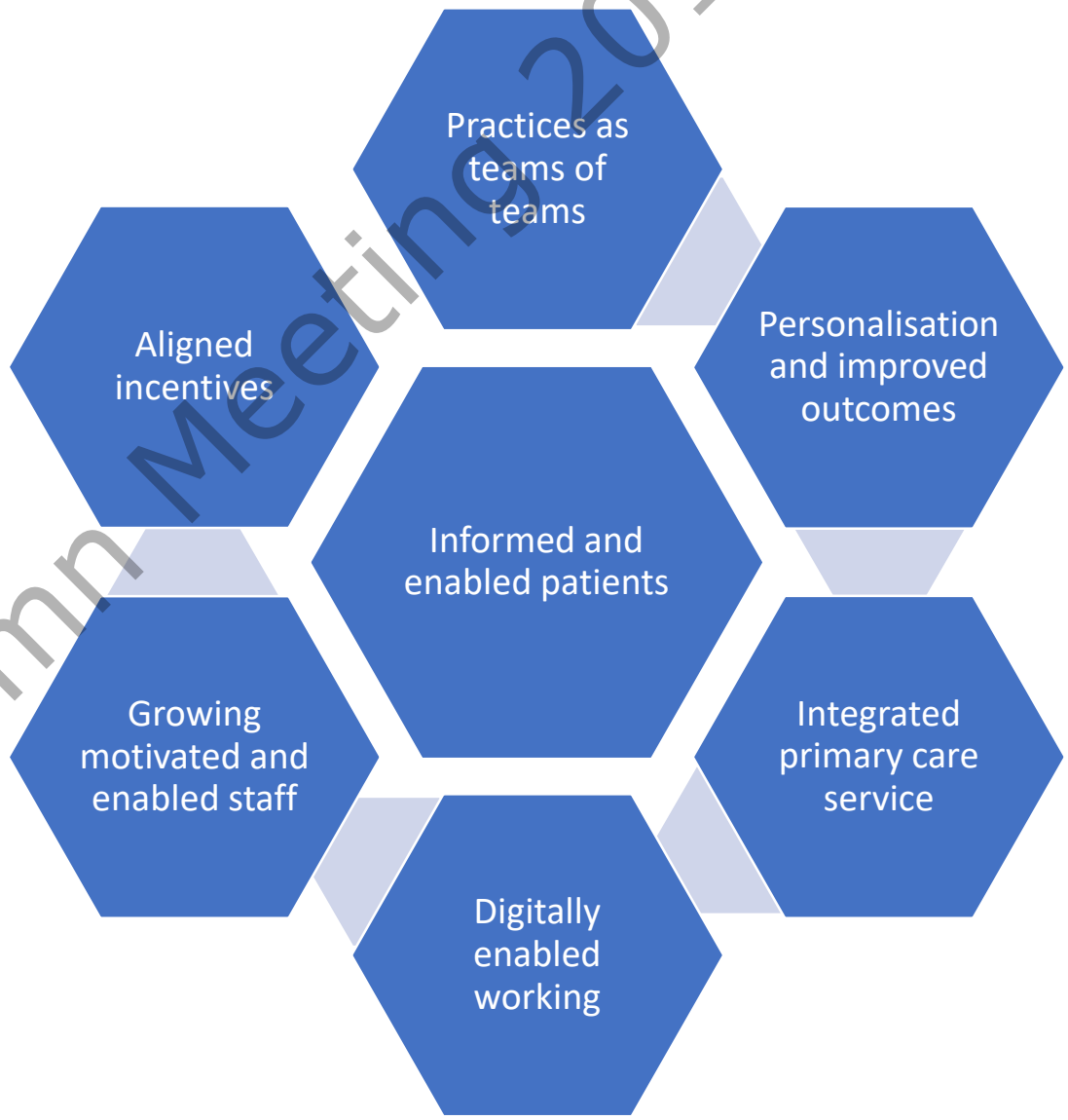
Primary care networks – key to the future

- 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.



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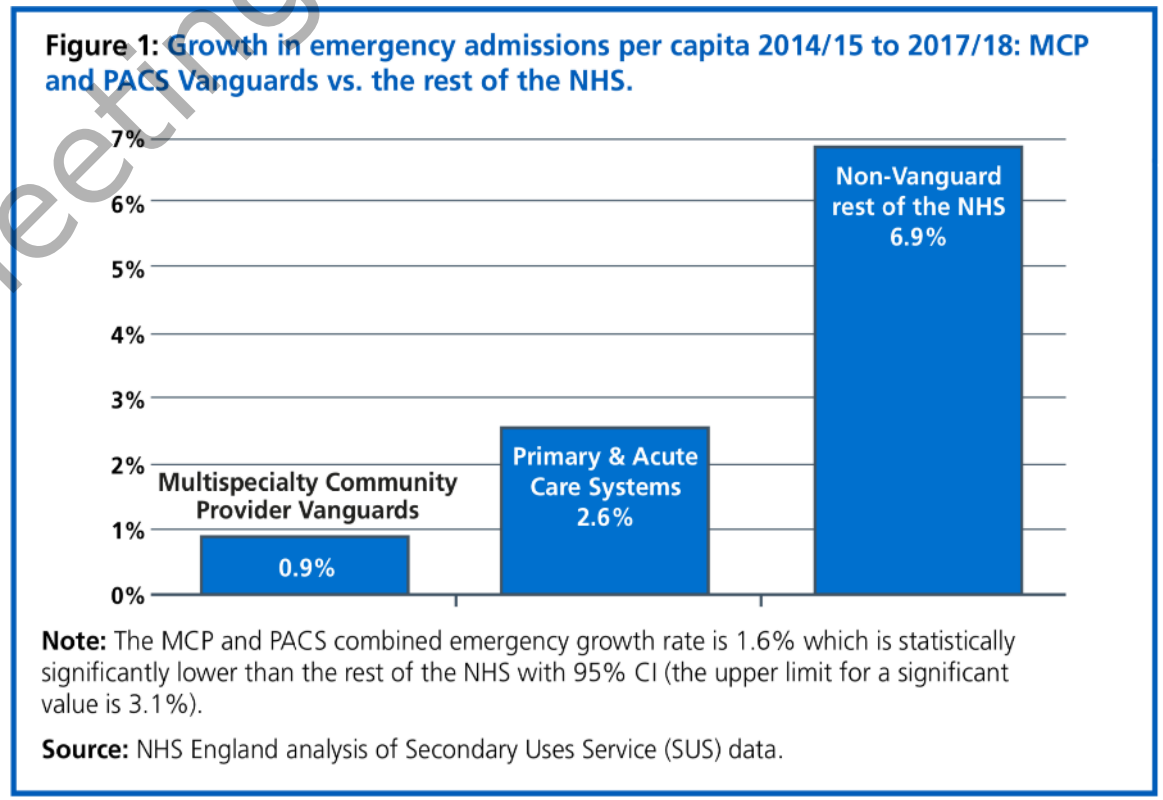
Primary care networks build on past work

Long history of GP collaboration

90% practices self-identified as ‘networks’ last year



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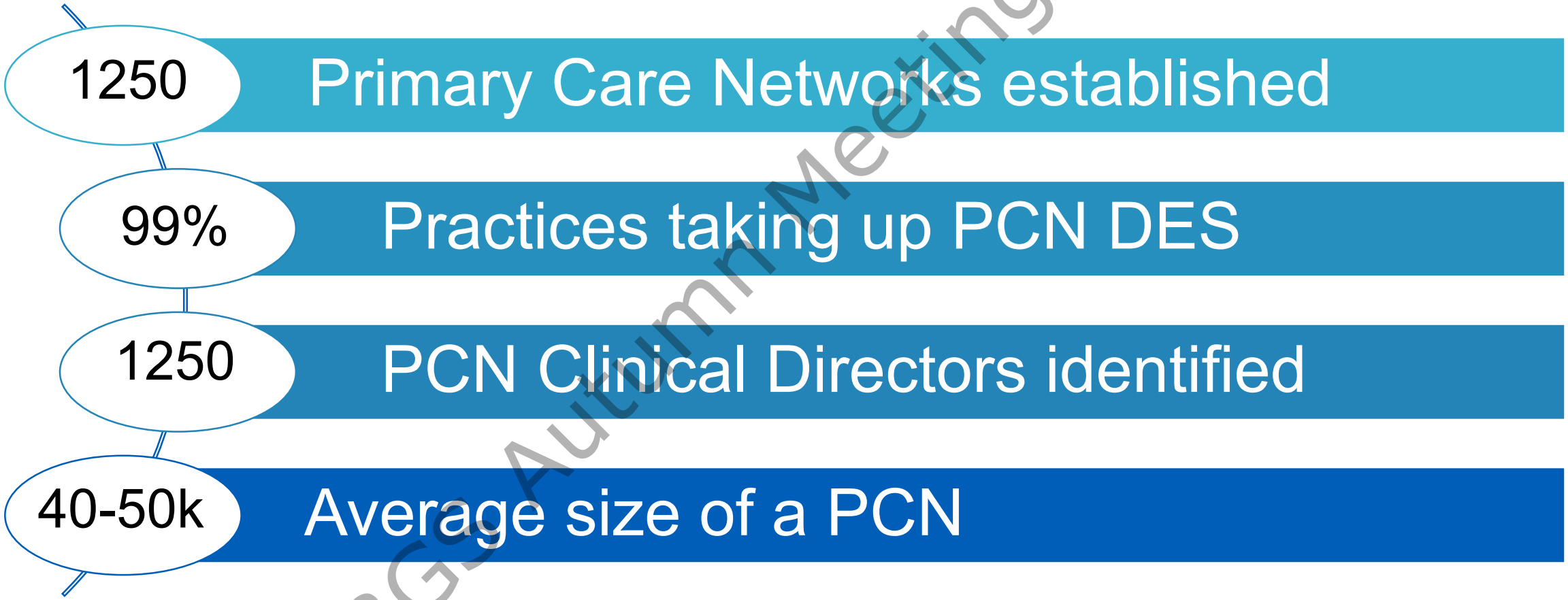
Since January 2019



*Rounded numbers

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PCN DES

- Funding for the core practice contract is fixed for each of the next five years, and **increases by £978 million in 2023/24.**

- **Up to £1.799 billion** will flow nationally through the Network Contract DES by 2023/24. This will include funding for the new additional role reimbursement scheme (with funding included for **20,000 additional staff**), network support and access.

- The Network DES has been introduced from 2019/20.
  - **In year one** it provides funding for practices to form into Primary Care Networks, appoint clinical directors, appoint clinical pharmacists and social prescribers.
  - **In year two** (2020/21) it will have the delivery of five service specifications to patients added to its requirements. PCNs will be able to appoint physician associates and physiotherapists alongside the two initial roles.
  - **In 2021/22** two more service specifications will be added. Paramedics, the fifth additional role, will be added to the scheme.

- **CCGs can of course continue to commission separate and complementary services** from the PCN or PCN member practices alongside the DES.

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Maturity depends on:

- Leadership, planning and Partnerships
- Population health management and use of data
- Integrating care
- Use of resources
- Development of people and partnerships

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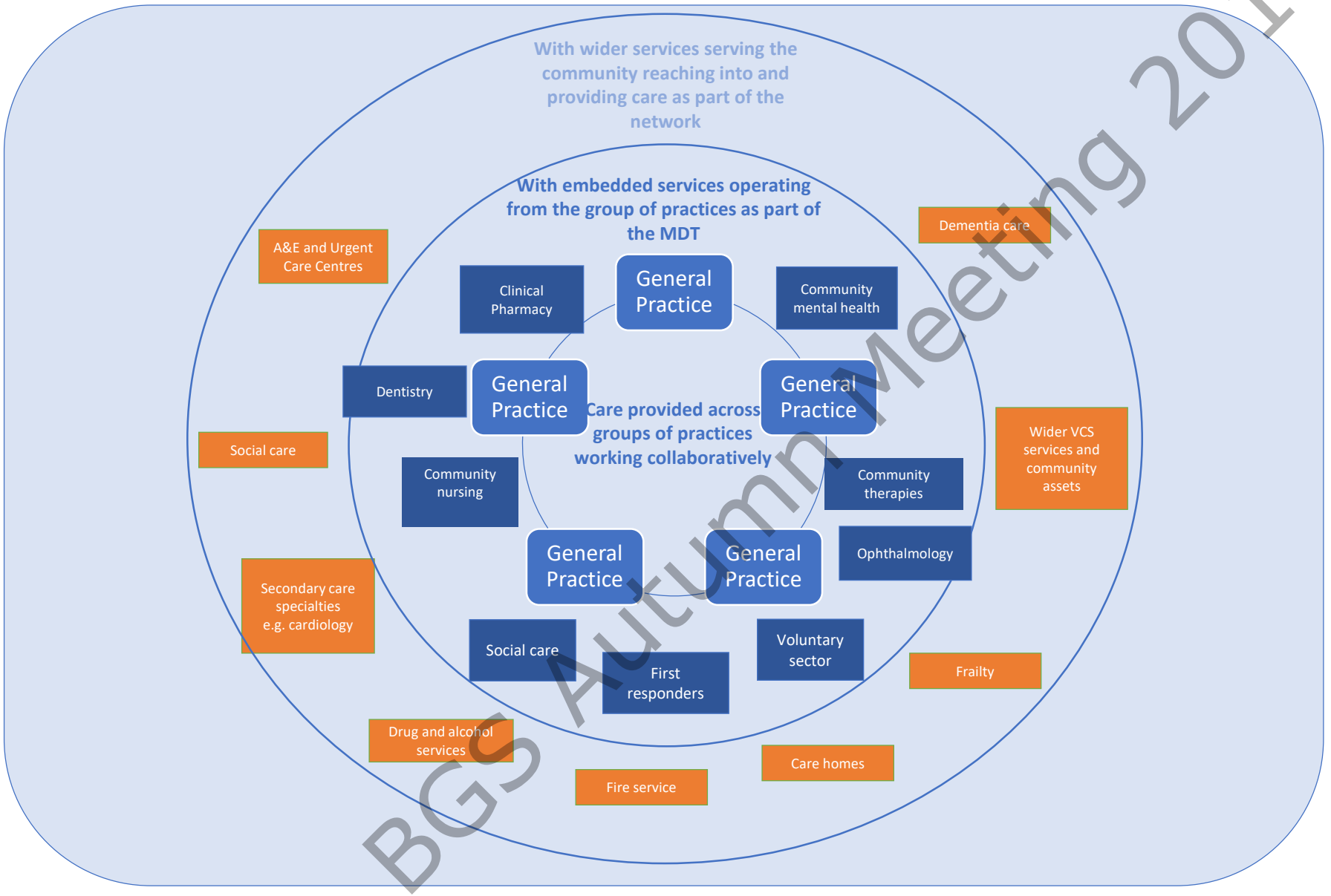
Primary care network : what it might look like



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Important to strike a balance

Ambition/
expectation

Reality/
Maturity

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Holding back expectations

- 5 new groups of staff to deploy
- MDTs to form with community services providers
- Relationships to build – internal and external
- 7 new service specifications to deliver
- ‘sort out’ access
- Deliver integrated care

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People with frailty and multiple long term conditions

NHS England

What will care look like on the ground?

Core characteristics

- Multidisciplinary teams (MDT) embedded within primary care networks or hubs, with access to skills across GP, nursing, social care, mental health, pharmacy, physios, occupational therapists and care coordination - addressing physical, mental and social needs.
- Integrated frailty models between networks and secondary care to reduce admissions, length of stay and delayed transfers of care (DTOCs).
- Risk stratification and case finding - with regular virtual, remote or in person review depending on patient risk - enabling proactive intervention. Patients regularly stepped up and down from MDT care dependent on need.
- Care planning reflecting patient preferences/choice, with proactive coaching to support patient activation and self-management.
- Real-time interoperable shared care records used by MDTs who know their patient cohort and each other by name.
- Rapid access home care (including for care home residents) provided by MDTs.

Networks have:

- An integrated complex care/frailty model in place with established processes for selecting patients.
- MDTs utilising and reviewing daily real-time data to intervene proactively to (a) avoid deterioration and admission and (b) ensure rapid discharge.
- MDTs demonstrating that they cover the skill groups listed.
- Partnership working with the voluntary sector and social prescribing in routine use.

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Multi-disciplinary teams

Primary care is the foundation of the NHS and has felt the pressure of rising demands and workloads, with an increasing burden of people living with long-term conditions and multi-morbidity. The NHS Long Term Plan recognised these challenges and over the next five years, primary and community care services will receive investment of £4.5 billion to offer more personalised, coordinated health and social care to their local populations through expanded multidisciplinary teams.

Among the ambitions of the plan are to:

- Develop more rapid community response teams to prevent unnecessary hospital spells and speed up discharges home
- Provide more personalised care to help more people to live independently at home for longer
- Deliver community-based physical and mental care for 370,000 People with severe mental illness each year by 2023-24
- Recruit and train between 4,000-5,000 social prescribing link workers to work in primary care networks

By working in a multiprofessional way, patients can access:

- More personalised care plans, enabling them to make decisions about managing their health so they can live the life they want to live based on what matters to them, working alongside clinical information from professionals who support them.
- More joined-up services between all health and social care services where all staff involved have knowledge of the patients individual health and social care needs.
- A wide range of professionals providing advice, support and care and developing different relationships with the patients to unlock extended patient services.

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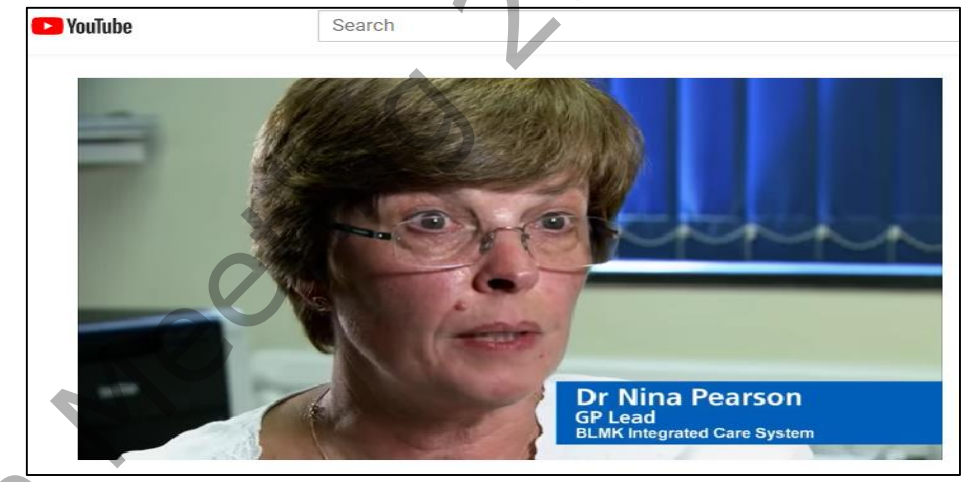
Multi-disciplinary working: Luton and Weymouth

Case study 1 : Thinking creatively about primary care in Luton

In Luton, practices are working together in groupings covering 30,000 - 70,000 patients, joining up different types of clinicians and bring together community services, social care, and mental health services around the practices to provide better care for patients.

Watch this case study at
https://www.youtube.com/watch?v=YLntGo-BhPc



Case study 2 : Now we have help - the future of health and social care

We worked with Age UK to produce this short film which tells the story of how joined-up care at Weymouth Hub in Dorset improved the lives of Dennis, who was living with multiple complex conditions, and his wife Jennifer, who cared for him. It shows how the NHS and local councils are working together to improve health and care.

Watch this case study at
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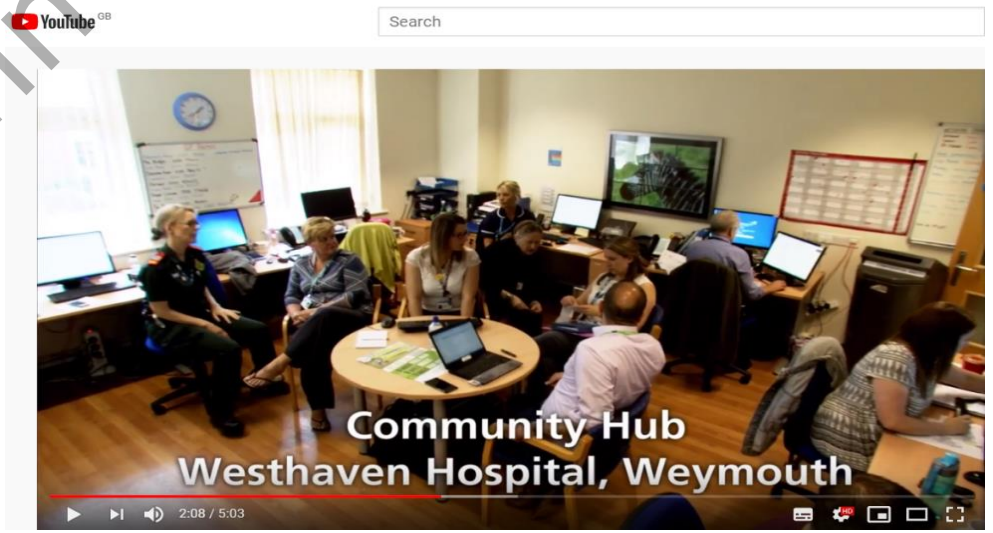

You can find further case studies on the FutureNHS platform, please email england.pcn@nhs.net to gain access.

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Thank you for listening

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