Primary Care Network Development - South West Clinical Senate

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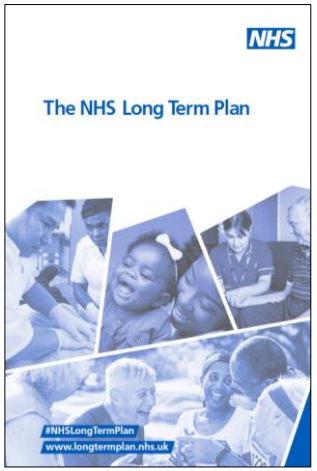
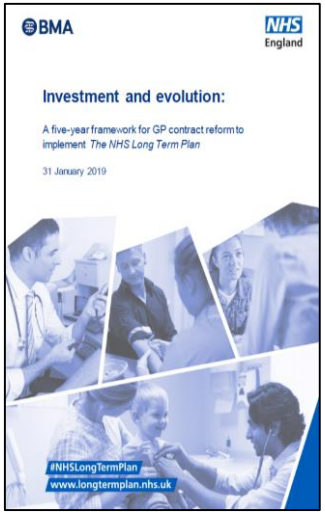
Primary Care and Systems Transformation

Context setting

- NHS England's Long Term Plan outlined the ambition for Integrated Care Systems (ICSs) to cover the whole country by April 2021. ICSs are a pragmatic and practical way of delivering the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.
- Primary care networks will be the building block of every ICS. Working with other partners to allocate resources and deliver care. This will support the planning of workforce, estates and digital at a network level.
- Primary care networks are central to the new service model for the 21st Century. They are a key ***delivery vehicle*** for the commitment to boost out of hospital care and provision of more personalised, digitally-enabled, population-focused care.
- Networks will deliver tangible benefits for patients and clinicians - delivering improved outcomes, an integrated care experience for patients, and more sustainable and satisfying roles for staff.





The vision for primary care networks

Networks will work collectively to change the way in which services are delivered to their patients. They will be focused on the process of care and working together collectively to improve care, striving for better quality for their patients.

Networks will deliver tangible benefits for patients and clinicians resulting in:

- improved outcomes for patients;
- an integrated care experience for patients;
- more sustainable and satisfying roles for staff, promoting development within multi-professional teams.

Networks will assess population health - focusing on prevention and anticipatory care - and operate in partnership with other agencies to address the wider determinants of health.

Care will be delivered as close to home as possible, with networks and services based on natural geographies, population distribution and need rather than organisational boundaries.

Seamless care (for both physical and mental health) across primary care and NHS community services, will remove the historic separation of these parts of the NHS.

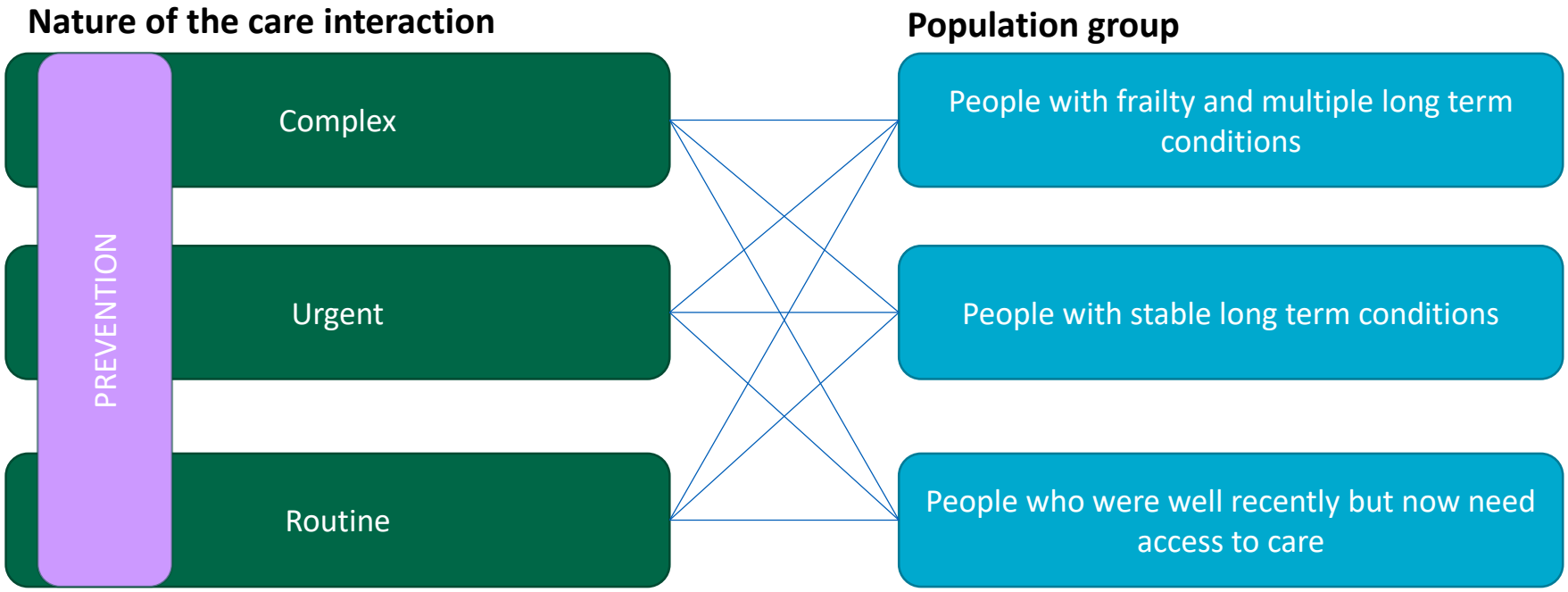
Integration across primary care networks and secondary care/place-based care will reduce demand for hospital-based care, with more clinically-appropriate secondary care in primary care settings.

The vision for primary care networks

- Joined up care planning, coordination and delivery will take place between primary care, community care, voluntary sector, social care, and other parts of local government, including public health, with NHS and social care teams working together in multidisciplinary teams (MDTs) and hubs. Services will respond to the needs of the communities they serve.
- Networks will fully harness the opportunities available from technology, including digital provision of care for patients (e.g. a digital front end), real time shared care records and business intelligence systems.
- Staff will have a more sustainable workload and more attractive, structured career pathways, that enable multidisciplinary working, portfolio careers and the ability to move between care sectors.
- Integration and partnership working with wider partners, in local government public health, fire, housing, police and education will help to address wider determinants of health.
- A business model to incentivise networks, with a contract for outcomes based commissioning, appropriate payment models and removal of potential barriers to integration, including estates and indemnity.
- Develop clinical and business leadership within and between networks and the wider health and care system with a strong provider voice of general practice.

What could the care model look like?

- Local systems and primary care networks may find it helpful to develop a version of their care model in a visual form as part of design conversations with clinical teams. The design of this is best tailored to local contexts, but networks may find it helpful to consider how their integrated models can operate holistically across their main population segments, and depending on whether patients' needs are routine, urgent or complex – recognising that these elements will often need to interrelate. The image below may help as a starting point for those conversations, and the care model components outlined in the remainder of this pack is organised along these themes.



- Preventative care spans all the care interactions
- Patients can move between the groups over time – groups are not intended to be mutually exclusive

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.

People with stable long term conditions

NHS England

What will care look like on the ground?

Core characteristics

- Care delivered by a team of people including skills across GP, specialist nursing, mental health, community and hospital specialists, interacting with patients in person, remotely and virtually as appropriate. Hospital trainees rotating through these roles. Most current outpatient services delivered in the network.
- Continuity of care, with diarised reviews from the usual, named clinician and relevant tests completed ahead of time.
- Digital front end, providing easy access to information for patients and allowing repeat prescriptions to be ordered.
- Coaching and use of technology to support patients to self-manage and stay well.
- Standardised treatment pathways, analysis of variation, and use of data to identify patients at rising risk and for primary and secondary prevention.
- Social prescribing and group consultation in routine use.

Networks have:

- A mechanism to identify patients at rising risk and in need of preventative intervention.
- Digital access allowing repeat prescriptions to be ordered and access to information for self management.
- Ability to book diarised review appointments.
- MDTs demonstrating that they cover the skill groups listed.
- Patients able to access traditional outpatient services in the primary care network.
- Partnership working with the voluntary sector and social prescribing in routine use.

People who were well recently but now need access to care

NHS England

What will care look like on the ground?

Core characteristics

- Digital front end (linked to NHS111) able to direct patients to self-care, pharmacists, GP, physio or other most appropriate care first time, in person or remotely.
- Patients can access records and book appointments, where appropriate, online.
- Use of technology to promote wellness and encourage attendance and adherence to medications.
- Joint working across networks to deliver access standard, with practices able to cross cover.
- For urgent care, a GP or other professional acting as coordinator for a team of clinicians, managing resources and matching to demand. Home visiting available through paramedic, advanced nurse practitioner or other clinician.
- Clinicians can easily access secondary care advice, with named clinician in common specialities.
- Seamless link to local out of hours services and urgent treatment centres with shared care record.
- Use of data to identify groups who are not yet unwell but could benefit from preventative medical or social intervention. Provision of information and support to patients to help them to stay well.

Networks have:

- Digital front end supporting effective navigation, signposting and advice for episodic needs, and ability to book appointments online where appropriate.
- Primary care network urgent care model fully integrated with NHS111, out of hours, urgent treatment centres and A&E, with shared care records.
- Patients being signposted to the most appropriate professional for their first contact.
- Access standards being delivered.
- Named secondary care clinicians for common specialities.
- A mechanism to identify patients at who would benefit from early intervention.

Core characteristics across all population cohorts

NHS England

What will care look like on the ground?

Core characteristics

- Practices collaborating with other providers around natural local communities, providing coordinated and anticipatory care.
- A business model for collaborative working and optimum use of collective resources within and across networks.
- Integrated population health models for those with: episodic needs; rising risk; and complex needs - informed by modelling through population health management analysis.
- Redesigned, evidence based pathways across primary/secondary care, consultant outreach and most outpatients delivered in the network.
- Focus on prevention, patient choice, and self care, connecting to a full range of statutory and voluntary services.
- Data and technology to assess population health needs, support clinical decisions, monitor performance and reduce variation.
- A workforce model that builds capacity and skills, gives greater resilience, sustainable workloads and supports portfolio careers.

Networks have:

- Established an agreed, shared, core care model for their local populations, with common and standardised operating procedures.
- Real-time population health management data and analysis in place that is used by all clinicians within the primary care networks and informs the focus of MDTs.
- MDTs meet the majority of local population health and care needs, with referrals outside the network, and admissions minimised.
- A real time shared interoperable care record that is read/write across all providers.
- A shared view of resources and ability to shift resources to address population need.

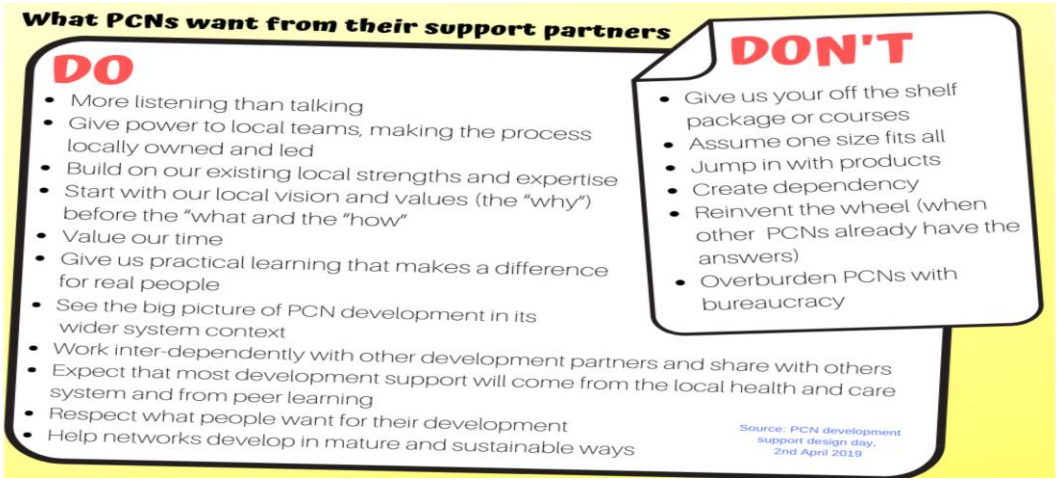
PCN Support: What we've learned

We understand the ask on PCNs is ambitious and they (and the systems they work within) will need support to help them mature and deliver a different experience for patients as well as creating more sustainable satisfying roles for staff.

To inform our support offer we have:

- Engaged extensively over the autumn/ winter
- Learnt from ICSs and other systems we have worked closely with in the last few years
- Continued dialogue with stakeholders and partners through multiple fora and platforms

This feedback has informed both the content of development support prospectus and a way of working with systems and regional teams.



A prospectus to shape PCN support

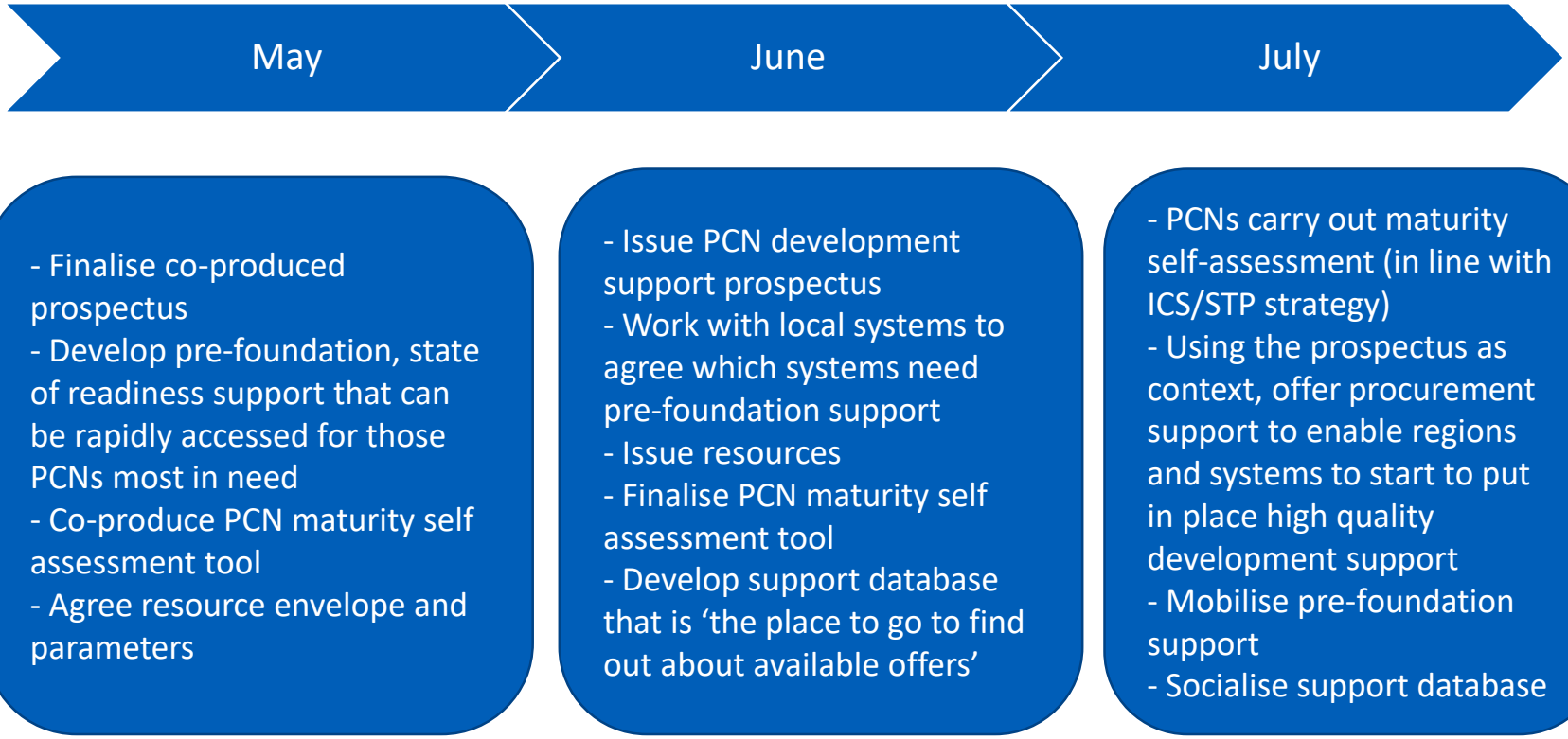
Based on feedback the decision has been made ‘not’ to procure development support nationally as one size does not fit all. It’s been agreed that development support funding will flow to ICS/STPs and working with their Regions they will use a *co-developed PCN development prospectus* that sets out ‘what good looks like’ to ensure that high quality development support is put in place.

- The draft prospectus describes several modules of support, these are:
  - Module 1: PCN set-up
  - Module 2: Organisational development support
  - Module 3: Change management quality and culture
  - Module 4: Leadership development
  - Module 5: Collaborative working (MDTs)
  - Module 6: Asset based community development and social prescribing
  - Module 7: Population health management

We will continue to develop this thinking with stakeholders throughout May with a view to being finalised in early June.

Stakeholders also expressed the importance in creating communities of practice and peer groups to continue to share learning, support and best practice. We will continue to think through how we can deliver this and make it sustainable for those involved in working in a PCN.

Support framework timeline



Next steps

- We need to continue to iterate the content of the prospectus and work with provider partners to ensure quality of support offered will meet expectations.
- Systems and PCNs will need to undertake self assessments to inform their development support needs.
- We will work with regions and local systems to identify those systems that could benefit from pre-foundation support.
- We will continue to develop the existing support database which captures the existing support offers from NHS teams and partner organisations.
- We will enable the resources for development support funding to flow to systems as quickly as possible.
- Systems and PCNs should continue to work together to develop robust development support plans so they are in a strong position to commission good development support based on their own local needs connected to their own maturity and system ambitions.