

## **Primary Care Networks Reference Guide: Draft pre-release**

This draft reference guide has been developed with input from a range of stakeholders to provide further information and guidance on what we mean by primary care networks. It contains initial information on the key areas to be considered in establishing primary care networks locally, including setting out the core characteristics of primary care networks, exploring what this might feel like in practice and considering how primary care networks might grow and mature over time.

**We are seeking comments to help shape and finalise the guide and would welcome any feedback – we intend to publish the guide later this year. Please send any comments or feedback to [england.PCN@nhs.net](mailto:england.PCN@nhs.net) by 20 August 2018.**

# Primary care networks

## Reference Guide

**Draft: as at 25/07/18**

# DRAFT

Primary care is the cornerstone of the NHS – providing holistic care to patients and serving the health needs of local communities. Effective primary care is characterised by the strength of team working and ongoing relationships between patients, GPs and other professionals. It has always worked in various forms and sizes, with some areas already coming together to provide care ‘at scale’. However, across England primary care has felt the pressure of rising demands and workloads, often within an increasingly fragmented landscape of health and care services.

Primary care networks support groups of practices to come together locally, in partnership with community services, social care and other providers of health and care services. Where emerging primary care networks are in place in parts of the country, there are clear benefits for patients and clinicians, and these approaches are emerging as the delivery model for primary care of the future. For example, the recent development of the ‘Primary Care Home’ approach builds on a history of primary care working in more integrated ways, drawing together and sharing existing good practice, and provides evidence that network-based models can improve care for patients while at the same time supporting clinicians to live sustainable lives.

Primary care networks build on the core of current primary care and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. Clinicians describe a change so that their work isn't about reactively providing appointments to patients on a registered list, but proactively caring for the people and communities they serve. They should be based on GP registered lists, typically serving natural communities of around 30,000 to 50,000, which experience has shown is the optimal size for integrated locality-based working. Networks should be small enough to still provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through deeper collaboration between practices and others in the local health and social care system. Networks will provide a platform for providers of care being sustainable into the longer term.

That is why [Refreshing NHS Plans for 2018-19](#) set out the ambition for CCGs to actively encourage every practice to be part of a local primary care network so that there is complete geographically contiguous population coverage of primary care networks as far as possible by the end of 2018/19.

This document provides more detail on what we mean by primary care networks, and contains initial information on the key areas to be considered in establishing primary care networks locally. It is made up of a section describing Primary Care Networks, and a second section on key enablers.

The Guide is a ‘live’ document which we will keep updating as we gather more examples and experience over time. We will also be providing further focused material for specific groups.



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## Where we are now – what we have heard from GPs and patients

The case for Primary care networks is that by working together, GP practices and other care providers can deliver better care for their patients, and better lives for their staff, than they can by working in isolation. What we hear from GPs and patients helps illustrate the case for change.

**GPs and General Practice continue to face significant and growing pressures. *GPs have told us:***

General practice continues to deliver excellent care in most places, and some GPs and other practice staff have managed to find ways to deliver great care and make their working lives sustainable. However, population growth, an ageing patient profile with more complex needs, and rising public expectations are placing ever greater pressure on practices, GPs and other staff. Increasingly the needs of patients are a blend of physical and mental health needs, social and environmental factors that require coordinated responses – well beyond the traditional medical model of care – which places further demands on practices both to navigate system for their patients and coordinate the response.

Workload is higher than ever, with GPs and practice staff working long hours and struggling to maintain a sustainable work/life balance. General practice has in many areas become a less enjoyable place to work, and morale is low. In many areas, it is becoming more and more difficult to recruit and retain staff in general practice.

To deliver the best outcomes for our communities and enjoyable careers for clinicians and wider staff, primary care needs to be thriving and a great place to work.

**Patient expectations are evolving. *The public has told us:***

In parallel, the public tell us that they want care to be more joined up, and that they rightly want to be more active participants in their own care.

While all patients are different, many tell us they want:

- services working better together, across health and social care
- for those with complex needs, a single point of access for help and support, with more streamlined assessments, reduced hand-offs, and professionals and organisations who work in a coordinated way
- access to local organisations outside the NHS that can provide additional help and support them to stay well
- a greater role in looking after their own health and well-being, supported by self-care information and advice
- quicker access to a flexible range of services, outside of hospitals, to manage more urgent needs
- direct access to a wider range of services, such as physiotherapy, dietetics, psychological therapies and antenatal care, and being able to access more diagnostic tests and services without having to go to hospital
- technology being harnessed to help them to self-care, care navigate, book appointments, arrange prescriptions, access records online and enable triage or patient consultations online.

## Primary care networks – a way forward

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In developing Primary care networks, we need to retain the very best of how wider primary care currently operates, whilst finding improved ways to deliver care that offers tangible benefits and improvements to patients, clinicians and the wider primary care team. This means a new model of primary care for now and for the future, where:

- primary care can continue to meet patients' and the wider public's changing needs, with the support of the rest of the health and care system
- GPs and other professionals have a manageable and appropriate workload and greater job satisfaction;
- primary care can attract and retain the staff it needs.

Experience from around the country has shown that practices working collaboratively and at scale as networks offers the opportunity for this to happen. By working collaboratively or more formally together, practices can become more resilient, improve work-life balance by deploying a wider team, and more effectively meet the holistic needs of their patients and populations.

Primary care networks should build on the core values and strengths of general practice. They involve staff from practices and other local health and social care providers working in close partnership, as one team. The aim should not be to reorganise for the sake of it, but to design and implement ways of providing services collectively, that meet the health and care needs of their local population in a resource-efficient way. They provide care that proactively supports health and wellbeing, ensuring timely and accessible care for those with straightforward episodic needs and fully coordinated and integrated approaches for those with more complex needs.

Most care will continue to be based around the general practice unit holding primary responsibility for a registered patient's needs. Additional services that are too big to be in every practice but which don't need to be delivered from a hospital should be delivered at the network level, allowing networks of practices to have a stronger prevention and population focus. Networks of practices can also have a greater voice in service redesign that reaches beyond traditional general practice, and ability to share a larger pool of resources for their local communities.

Collaboration and integration should be the core characteristic of a network, with a number of ways people can access services, tailored to different population groups. This should include more effective ways of using technology and supported self-care models, and be firmly rooted in multi-professional, multi-service delivery with general practice acting as the primary care management centre ensuring that patients receive the right care from the right professional at the right time using the right channel (or channels) for their particular issue (online, by phone or in person).

## What could Primary care networks mean for patients, practices and others?

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### Patients should experience:

- **Joined up services**, where everyone they engage with knows about previous interactions
- **Access to a wider range of professionals and diagnostics** in the community, so they can get access to the people and services they need in a single appointment
- **Different ways of getting advice and treatment**, including digital, telephone based and physical services, matched to their individual needs
- **Shorter waiting times**, with appointments at a time that work around their lives
- **Greater involvement**, when they want it, in decisions about their care
- **An increased focus on prevention** and helping people to take charge of their own health, enabling them to stay out of hospital

### Practices should experience:

- **Greater resilience** by sharing staff, buildings and other resources, helping to smooth out fluctuations in demand and capacity and make the most efficient use of resource
- **A more sustainable work/life balance**, as more tasks are routed directly to appropriate professionals, e.g., care navigators, social workers, physios, pharmacists and counsellors
- **More satisfying work**, with each professional able to focus on the tasks they do best
- **Greater influence** on decisions made elsewhere in the health system
- **Ability to provide better treatment to their patients**, through better access to specialists in the community, diagnostics, and partnership with community services, social care, and voluntary organisations

### Wider health and care partners should experience:

- **Cooperation across organisational boundaries** to allow greater join up of **services**
- **Primary care providers as core partners in system decision making**, helping to drive a more population-focused approach to decision making and resource allocation
- **A wider range of services in the community** so patients don't have to default to the acute sector
- **More resilient primary care**, acting as the foundation of integrated systems

## The core characteristics of Primary care networks

Networks need to be small enough to maintain the traditional strengths of general practice in maintaining continuity of care, local ownership, and personal relationships between staff. They need to be large enough to provide resilience, support the development of integrated teams made up of several professional groups, and reduce demands on individual staff members. The exact size will be determined locally. However, experience from those already developing Primary Care Networks, like Primary Care Home and other sites has shown that, by serving geographically coherent populations of around 30-50,000, networks are able to realise the benefits of working at scale while also maintaining the traditional strengths of general practice in building relationships and providing continuity of care. Through working at this scale, primary care networks are able to develop a number of core characteristics, as outlined below.

### The core characteristics of a Primary care network are:

- **Practices working together and with other local health and care providers**, around natural local communities that make sense geographically, to provide coordinated care through integrated teams
- **Providing care in different ways to match different people's needs**, including flexible access to advice and support for 'healthier' sections of the population, and joined up multidisciplinary care for those with more complex conditions
- **Focus on prevention, patient choice, and self care**, supporting patients to make choices about their care and look after their own health, by connecting them with the full range of statutory and voluntary services
- **Use of data and technology** to assess population health needs and health inequalities, to inform, design and deliver practice and population scale care models; support clinical decision making, and monitor performance and variation to inform continuous service improvement
- **Making best use of collective resources across practices** and other local health and care providers to allow greater resilience, more sustainable workload and access to a larger range of professional groups

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## What does a Primary care network feel like in practice?

## An example from a Primary Care Home site

Primary Care Homes are a type of Primary care network. In this example, the practices decided to merge early in their journey. Experience from other sites has shown that much can be achieved through collaboration, without a formal merger.

*St Austell Healthcare has historically had high levels of long-term unemployment, socioeconomic deprivation as well as a high prevalence of chronic disease and obesity. Prior to 2014, four GP practices were working in isolation, struggling with high workloads and recruitment. In 2014 one large practice with 10,000 patients and no permanent doctors closed placing the remaining three under further strain. The three practices took on a one year contract to run the failing surgery and in May 2015 they merged with a total of 32,000 patients. They became a primary care home rapid test site in December 2015.*

*The primary care home model has offered a framework to redesign services to provide a sustainable future and offer new services with secondary and community care partners as well as the third sector.*

*St Austell Healthcare has introduced an active social prescribing scheme, integrated health and social care services and invested in multidisciplinary working increasing skills to create the environment that young trainee doctors and other staff would like to work in.*

*They've split acute and chronic work and now have an acute care hub with a nurse-led minor illness team and an acute visiting service with emergency care practitioners taking on many of the home visits. Community and district nurses are co-located at the hub which sees people who need an urgent same day appointment. They have two pharmacists working in the practice carrying out medication reviews and supporting patients with medication queries. Many admin staff are receiving training and being encouraged to gain level 5 diplomas.*

*As one entity, the PCH now has a much better working relationship with commissioners, acute trust, the voluntary sector and their community. The social prescribing scheme has had positive impacts on prevention and population health (wellbeing scores increased and weight loss).*

*The PCH has a 'grow your own' approach to recruitment – it is a training practice which now not takes not only GP trainees but also F2 doctors, year 5 medical students and year 3 nursing students. It is also about to take paramedic students, and postgraduate pre-reg pharmacists in conjunction with local acute trust. Through this approach, it is finding that many GP trainees are nursing students are wanting to stay. Advanced nurse practitioners and paramedics are also attracted to their innovative ways of working.*

## Another example of a network

Still to be added

**Over the coming months we will be building a library of case studies to share experiences with all those who are establishing Primary care networks**



## The journey of development for Primary care networks in a health system – maturity matrix

Our learning to date tells us that Primary care networks will develop and mature at different rates. Laying the foundations for transformation is crucial before taking the steps towards a fully functioning Primary care network. This journey might follow the maturity matrix below.

### Foundations for transformation

**Plan:** Plan in place articulating clear vision and steps to getting there, including actions at network, place and system level.

**Engagement:** GPs, local primary care leaders and other stakeholders believe in the vision and the plan to get there.

**Time:** Primary care, in particular general practice, has the headroom to make change.

**Transformation resource:** There are people available with the right skills to make change happen, and a clear financial commitment to primary care transformation.

### Step 1

**Practices identify PCN partners** and develop shared plan for realisation.

**Analysis on variation** in outcomes and resource use 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.

**Integrated teams**, which may not yet include social care and voluntary sector, are working in parts of the system.

Standardised end state **models of care** defined for all population groups, with clear gap analysis to achieve them.

Steps taken to ensure **operational efficiency** of primary care delivery and support struggling practices.

Primary care has a **seat at the table** for system strategic decision-making.

### Step 2

PCNs have **defined future business model** and have early components in place.

Functioning **interoperability within networks**, including read/write access to records, sharing of some staff and estate.

All primary care clinicians can access **information to guide decision making**, including risk stratification to identify patients for intervention, IT-enabled access to shared protocols, and real-time information on patient interactions with the system.

Early elements of **new models of care** in place for most population segments, with **integrated teams** throughout system, including social care, the voluntary sector and easy access to secondary care expertise. Routine peer review.

**Networks have sight of resource use and impact on system performance**, and can pilot new incentive schemes.

Primary care plays an **active role in system tactical and operational decision-making**, for example on UEC

### Step 3

**PCN business model** fully operational.

**Fully interoperable IT, workforce and estates** across networks, with sharing between networks as needed.

**Systematic population health analysis** allowing PCNs to understand in depth their populations' needs and design interventions to meet them.

**New models of care** in place for all population segments, across system. Evaluation of impact of early-implementers used to guide roll out.

PCNs take **collective responsibility for available funding**. Data being used in clinical interactions to make best use of resources.

**Primary care providers** full decision making member of ICS leadership, working in tandem with other partners to allocate resources and deliver care.

## How primary care will work at different levels of health and care systems

In Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), NHS organisations and local government are increasingly working together to provide integrated care for local people. Many STPs and ICSs have identified three system 'levels': **neighbourhoods**, built around primary care networks; **places**, integrating care between local hospitals and local authorities; and **systems**, which undertake strategic planning, allocate resources, and deliver some specialised services.

Primary care will play a crucial role at all of these levels. Primary care networks will deliver integrated services to people in neighbourhoods, as the foundation of an effective health system. In places, primary care will interact with hospitals and local authorities, working together to meet the population's needs. In some systems, federations will operate at the place level to support primary care networks. Finally, at the system level, primary care as a provider will increasingly participate in system decision making.

Networks create an opportunity for primary care to have a greater voice in both the design and delivery of 'place' based care with hospitals and local authorities, than may have been feasible historically in arrangement of individual separate practices. They provide a mechanism where primary care can stand shoulder to shoulder with NHS trusts and FTs.

| Level         | Pop. Size | How primary care fits in  |
|---------------|-----------|---|
| Neighbourhood | ~50k      | <ul style="list-style-type: none"> <li><b>People</b> can access joined up, proactive, personalised care</li> <li><b>Practices</b> continue to provide core services</li> <li><b>Primary care networks</b> bring resilience and differentiated, multidisciplinary care</li> </ul>                                    |
| Place         | ~250-500k | <ul style="list-style-type: none"> <li>In some systems, <b>federations</b> support efficiencies of scale and provide a voice for primary care</li> <li>Primary care <b>interacts with hospitals</b>, mental health trusts, local authorities and community providers to plan and deliver integrated care</li> </ul> |
| System        | 1+m       | <ul style="list-style-type: none"> <li>Primary care participates as an <b>equal partner in decision</b> making on strategy and resource allocation</li> </ul>   |

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## Key enablers

The following slides provide initial resources around a number of the key enablers that will underpin the effective development of Primary care networks.

This section will be updated on a regular basis to provide up to date information, advice and guidance on Primary care networks and to share learning and experience as networks develop.

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## Workforce

Many networks are already developing shared approaches to developing their workforce. They are finding that collaborating at scale presents greater opportunities to recruit and build a more multi-disciplinary workforce to meet the specific needs of patients, whether employed directly or through partnership with other local providers. Some GP practices are now able to embrace diversification of staff and new roles as Primary care networks are enabling any risk of staff with new ways of working to be shared across a larger footprint. This making primary care a more attractive and enjoyable place to work, with increasing job satisfaction and career options.

**What are Primary Care Networks doing?**

A range of different workforce-related initiatives are being introduced by PCNs, including:

- having a common approach to **planning the workforce** in primary care
- contributing as a significant stakeholder to priorities for **workforce training** in the local and regional health economy
- having some **shared staff** beyond the traditional skill mix of general practice
- enhancing **career options** and **job satisfaction**
- providing relevant and high quality **staff development** together

**Practical considerations:**

- **What is the desired size and skill mix for the network? Information needed:**
  - Anticipated needs in the population.
  - Design of the care model(s) to meet those needs.
  - Current workforce numbers and anticipated trends.

**Primary Care Home: population health-based workforce redesign**

The NAPC have worked with Primary Care Home sites to develop a guide on population health-based workforce redesign. It looks at how to redesign and develop a Primary Care Home workforce through population health-based workforce redesign and team-based working.

[\[Include link\]](#)

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## Patient and public engagement

To meet public expectations, Primary care networks should develop a extensive culture that welcomes authentic patient partnerships – facilitating greater shared decision-making between patients and clinicians both in an individual's own care but also in the processes of designing and delivering care.

**Key principles**

- Patient involvement means more than simply engaging people in a discussion about services. Involvement means having the patient voice heard at every level of the service.
- Evidence shows that patient safety improves when patients are more involved in their care and have more control
- Patient involvement is crucial to the delivery of appropriate, meaningful and safe healthcare and is essential at every stage of the care cycle: at the front line, at the interface between patient and clinician; at the organisational level, and at the community level.
- This should include participation in decision-making, goal-setting, care design, quality improvement, and the measuring and monitoring of patient safety.
- Patients and their carers should be involved in specific actions to improve the safety of the healthcare system and help the NHS to move from asking 'What's the matter ?' to 'What matters to you ?'. This will require systems to learn and practice partnering with patients, and to help patients acquire the skills to do so.

**Primary care networks should consider:**

- Involving People in Health and Care <https://www.england.nhs.uk/participation/involvementguidance/> – the statutory guidance to CCGs on involving patients and the public should be the starting place for Primary care networks.
- Thinking about what the range of community networks are in their local area and considering how to work with them for the benefit of the population, particularly where better engagement leads to patients accessing other local services in a more standardised way, for example Citizens Advice Services. A Primary care network could have an effective working relationship across an area with a single Citizens Advice Bureau who could then deploy their services in more effective ways.
- Patient Participation Groups are the natural place to engage. The local Healthwatch should be invited to contribute, influence and should have a thorough understanding of their local networks and communities.
- Primary care networks need to ensure that they have good connections in to marginalised communities.
- Most areas have a Council for Voluntary Service / Voluntary Action type organisation – early connection can be helpful as they will have local networks including social housing providers and volunteer projects where general practice and primary care may benefit from these greater connections.

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## How technology-enabled care can support a network

Networks can be supported through information and technology to deliver better health for their population, better care for patients and lower costs. This should be through:

- (i) **empowering the person** to maintain their own health, manage their illness or recovery, and interact with the NHS in way that improves convenience and effectiveness for the individual and their clinical team
- (ii) **supporting clinicians** in delivering high quality care at all times, as part of a network of professionals who can communicate easily with each other, and with access to the patient's records and care plan at the right time and in a useable format, supported by the best in decision and monitoring tools
- (iii) **integrating services across health and social care** so that patients receive support and care in the right place that is most convenient to them, maximising the ability of patients to maintain their health and their independence during illness, and enabling monitoring and prediction so that problems and risks are identified and managed as quickly as possible.

Across a network there is therefore an opportunity to manage care effectively through a combination of the use of digital triage for urgent episodic needs, and more sophisticated home monitoring and face-to-face care for complex patients. Networks are of a scale where there can be a blending of digital or face-to-face services as appropriate, dependent on need, whilst maintaining a whole population approach to care across the community. Those Primary care network that are most successful are able to connect effectively to the wider health and social care system, benefitting from even greater scale.

### Five key areas of Technology enabled care services that have an emerging positive evidence base:

1. **Online consultation:** involving the use of apps or web portals for patients to contact their practice about a clinical problem or query
2. **SMS text messaging:** used to provide patients with alerts and reminders to provide certain behaviours
3. **Telemonitoring:** involving the submission by the patient of physiological readings for examination and assessment remotely by a clinician
4. **Web-based interventions;** using websites, discussion fora, message boards and similar functionality
5. **Mobile phone digital health 'apps':** an area where there is some, but not a lot of evidence. Indications are that this is likely to grow with providers' and commissioners' growing interest.

### Tools and information to empower patients and citizens to take control include:

- **Telehealth** – the remote monitoring of a patient's health status and its use to vary or personalise care
- **Telecare** – the placing of healthcare technologies such as monitors, sensors and communication devices in the patient's home
- **Telemedicine** – the use of remote consultation to deliver care at a distance from the healthcare provider
- **Telecoaching and related approaches** – the provision of advice or talking therapy 'at a distance'
- **Self-care apps** – software provided on mobile devices which aims to support the delivery of treatment or preventative care

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## How a network might benefit from information and information systems

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Networks can be supported through information and technology to deliver better health for their population, better care for patients and lower costs. This should be through:

(i) **Managing the health system** in a way that minimises the burden of data collection, brings together the data necessary for quality improvement, and creates a single source of truth for decision making, and enables complex modelling and forecasting to enhance health and care planning

Accurate, meaningful information will be crucial for the delivery of population based care to ensure services are designed around the needs of the local population. Primary care networks should consider (i) robust information systems supplying and sharing data upon which informed decisions can be made and (ii) adopting technology-enabled care that enables higher levels of patient-activation and self-care and that digitally integrates clinical models.

**Core components**

This may require:

- Business intelligence systems and data analytics for population segmentation and risk stratification, and which enable a focus on high quality preventative and proactive care
- Clinical systems to improve clinical decision making (to support better diagnosis, pathways of care and improve referrals to the most optimal services), enable coordinated care, care planning and case management – and that enable shared or linked systems across providers, such as through a hub-based model, and provision of real-time ‘advice and guidance between clinicians
- Ability for primary care providers to see how they are performing against other networks and practices through real-time dashboards – supporting peer reviews; the impact they are having on the system and to reduce variation
- Consistent deployment of high value and low cost proven technology-enabled care



## Clinical Governance

Collaboration at scale provides a great opportunity to identify and address quality issues, and introduce a culture of continuous improvement. The increased amount of data and information available provides an important basis to focus on quality improvement. Bringing together the different skills and perspectives of people across the organisations in the network to learn from each other, consider variation across providers and improve services for patients.

**Key principles to consider:**

- Enhancing the 'bottom up' capacity of primary care networks to identify and respond to new ideas.
- Ensuring organisations across a primary care network continually embrace an ethic of learning.
- Patients and their carers should be present all levels of healthcare organisations.
- Seeking out the patient and carer voice as an essential asset in monitoring the safety and quality of care.
- Sharing data on quality and safety in a timely fashion with all parties, including, in accessible form, with the public.
- Embedding patient safety sciences and practices as part of the education of all health care professionals.
- Organisations across the primary care network should listen to the voice of staff to help monitor the safety and quality of care and variation among teams and care pathways.
- Organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.
- Primary care networks should consider how to monitor the status of patient acuity and staff workload in real time, and make adjustments accordingly to protect patients and staff against the dangers of inadequate staffing
- Primary care networks should include processes for monitoring and evaluation and sharing with NHS England in order to understand what works and to assure that best processes are spread and scaled to benefit all patients in the system.
- Supervisory and regulatory systems should be simple and clear. We need to avoid diffusion of responsibility.
- All incentives (internal and external to the primary care network) should point in the same direction.

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Each provider coming together in a primary care network will hold or use existing estate, the picture of which is likely to be based largely around individual and separate sites. Primary care networks therefore have an opportunity to consider how they want to use their collective estate to deliver their chosen care model, and through working more collaboratively can agree how they may wish to use their premises differently, for example through co-location or housing joint clinics.

Primary care networks may wish to consider:

- How to make the best use of collective estate
- How estate can be flexible and fit to meet the increasing emphasis on delivery of out of hospital services and facilitate hub or network working
- How to see beyond current use of estate to ensure it is an enabler rather than a barrier to providing integrated care
- How to use estate which is being efficiently, appropriately and to its full capacity
- How the primary care network will feed into strategic estates planning function at STP level

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## What arrangements need to be in place for a Primary care network to operate?

Primary care networks should consider what form they will operate under in order to deliver their care model. This form, or business model, will need to reflect the care model which the Primary care network is seeking to provide.

There are many primary care networks across the country whose providers are successfully working differently and collaboratively but do not have any formal arrangement, such as a collaboration agreement, outlining this. Some existing primary care networks have taken the decision to formalise their relationships with a collaboration agreement or MOU, which requires providers to agree how they will work together. The process of agreeing this in a more formal way may be helpful for providers to crystallise their aims, build relationships and start to share the risk and resources between them.

In some cases, commissioners may decide to make adjustments to local contracts which can help the Primary care network to flourish. For example, this might be through agreeing integration objectives in providers' contracts, through buying services differently, or ultimately, the commissioning of integrated services through a new contract and via a procurement.

### Key points – collaboration agreements

- The network does not hold any service contracts with the commissioner (individual provider contracts remain), but instead different ways of working are achieved through collaboration
- A collaboration agreement is signed between all providers setting out how they will work together (could be an alliance contract or an MOU in early stage of maturity)
- The agreement would set out how the network will work together (governance), how assets and workforce may be organised / shared and how incentives will work at the network level and align with the rest of the health and social care system
- Does not require any changes to providers' contracts, unless otherwise agreed

### Key points – contracting

- Occurs when a commissioner decides to let a new contract for network based services for the population and the network is successful in bidding for this contract
- This could be for a specific service or for a wide range of wraparound services, on top of core primary medical care contracts
- There could be subcontracting arrangements in place between the providers involved
- As a collection of providers, a network is not able to hold a contract. In order to do so, one of the providers could hold the contract on behalf of the network (as a 'lead provider') or the network will need to consider joint venture vehicles or organisational mergers

Across these options, the organisational arrangements of the parties involved can range from maintaining individual identities to merging into one organisation

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Annex: illustration of possible care model

## How can a collaboration agreement support a primary care network?

A collaboration agreement is an important tool for providers within a network to use to formalise their aims and objectives, and set out how they will work differently and more closely with each other in order to achieve these. Each primary care network will have different aims and different relationships to consider, but there are common principles which could be covered by any agreement.

### 3 important areas that collaboration agreement could cover

- 1 The **terms and governance** of the collaborative working
  - Agree and set out how all organisations will work towards aligned objectives and act in a way that is 'best for service' and for patients
  - Adopt consensual/unanimous decision making, and ensure every organisation has a voice.
  - Establish an open and trusting culture
  - Agree how objectives will be met, such as through multi-disciplinary teams and agreed pathways
- 2 How **incentives** will operate at the network level
  - Agree how incentive alignment can enable primary care providers to have a greater ability to influence activity in the wider health and social care system
  - Establish how incentives can be used to develop the network and build its maturity
  - Agree how the network can be incentivised to optimise the use of their resources to benefit the wider health and social care system (for example, deploying resource in different ways to help reduce delayed transfers of care (DTC) or, where appropriate, emergency admissions)
  - Explore how existing incentives (e.g. QOF, CQUIN and QPS) could be delivered in a network context
- 3 How **workforce and assets** can be shared
  - Agree how to make better use of estate and facilities across the system
  - Adopt a system-wide approach to data sharing and analytics
  - Coordinate system-wide approach to workforce – e.g. MDTs offering a holistic rather than disease based approach

NHS England has developed a primary care network template MOU and agreement [[Include link](#)]

**What does this mean for the GP contract?** NHS England set out in its Board paper in July 2018 that negotiations with the BMA would take into account the “development of 1000-1500 primary care networks as an expanding service delivery unit.” At the same time NHS England published a review of the Quality and Outcomes framework which explained the intention to trial a network version of QOF with a select number of sites from 2019 for 2 years. Discussions with the BMA and with local sites has begun on both these proposals.

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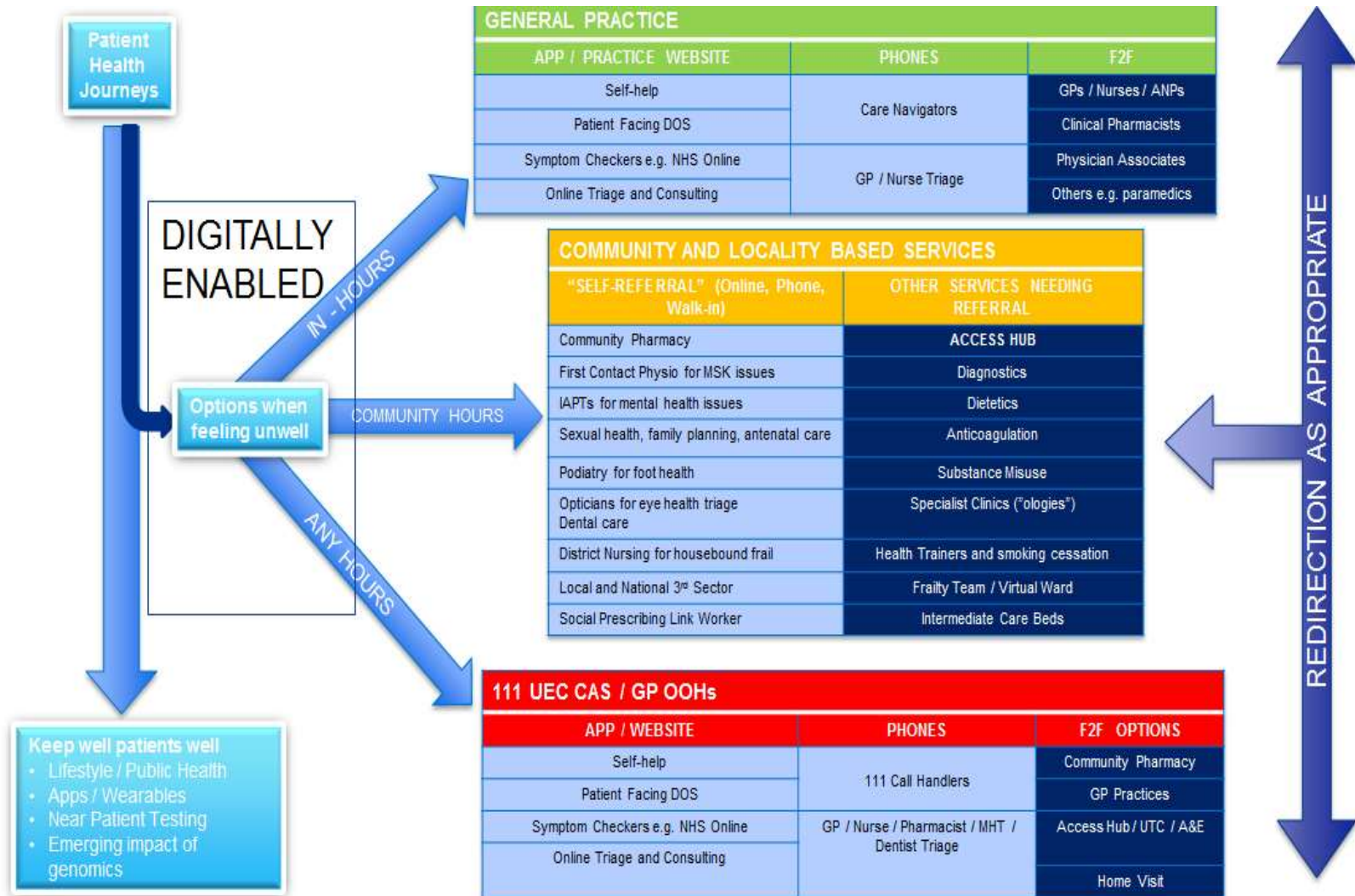
8 Business model

Annex: illustration of possible care model

## An illustration of a possible care model at the heart of primary care at scale

It will clearly be for localities to determine the right design of services for their local population. An example of how services could be configured is set out below.

Localities should also consider whether some services in this illustration might be best delivered locally across larger populations and across networks of networks, for example access or urgent and emergency care.





# Another illustration of a possible care model at the heart of primary care at scale shown by Primary Care Home

