Joint Health Overview & Scrutiny Committee - 13th February 2020

Sandwell and West Birmingham CCG Primary Care Networks (PCNs)

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1. Background

1.1 Refreshing NHS Plans for 2018-19[1] set out the ambition for CCGs to actively encourage every practice to be part of a local primary care network to ensure coverage of the whole country as far as possible by the end of 2018/19.

1.2 The NHS Long Term Plan[2] published in January 2019 then provided a clear ambition for primary care networks within the wider health care system announcing that as part of a set of multi-year contract changes individual practices in a local area would enter into a network contract, as an extension of their current contract, and have a designated single fund through which all network resources would flow.

1.3 The core characteristics of a PCN are:

- Practices working together and with other local health and care providers, around natural local communities that geographically make sense, to provide coordinated care through integrated teams
- Typically a defined patient population of at least 30,000 and tend not to exceed 50,000
- 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 care for those with complex conditions
- Focus on prevention and personalised care, supporting patients to make informed decisions 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 populations scale care models; support clinical

[1] NHSE – Refreshing Plans for 2018/19 published 2nd February 2018 https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf

[2] NHSE The Long Term Plan published January 2019 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

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.

1.4 Primary care networks build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. Clinicians describe this as a change from reactively providing appointments to proactively caring for the people and communities they serve.

1.5 Primary care networks will provide proactive, coordinated care to their local populations, in different ways to match different people's needs, with a strong focus on prevention and personalised care. This means supporting patients to make informed decisions about their own health and care and connecting them to a wide range of statutory and voluntary services to ensure they can access the care they need first time. Networks will also have a greater focus on population health and addressing health inequalities in their local area, using data and technology to inform the delivery of population scale care models.

1.6 Over time, primary care networks will be expected to have a wide-reaching membership, led by groups of general practices. This should include providers from the local system such as community pharmacy, optometrists, dental providers, social care providers, voluntary sector organisations, community services providers or local government.

2 The Network Contract Direct Enhanced Service

2.1 Investment and Evolution A five-year framework for GP contract reform to implement The NHS Long Term Plan[3] (31st January 2019) agreed between NHS England and the BMA General Practitioners Committee (GPC) in England translated the commitments made in The NHS Long Term Plan into a five-year framework for the GP services contract.

2.2 Within this framework a new 5 year Network Contract Direct Enhanced Service (DES) was described, with a clear plan for investment, the appointment of a Clinical Director Role and additional roles including Clinical Pharmacists and Social Prescribing Link Workers (2019/20); First Contact Physiotherapists and Physician Associates (2020/21) and First Contact Community Paramedics (2021/22). A requirement to deliver extended access hours and a list of seven services that PCNs will be required to provide:

[3] Investment and Evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan, published 31st January 2019 https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

i. Structured Medications Review and Optimisation; (2020/21)
ii. Enhanced Health in Care Homes, to implement the vanguard model; (2020/21)
iii. Anticipatory Care requirements for high need patients typically experiencing several long term conditions, joint with community services; (2020/21)
iv. Personalised Care, to implement the NHS Comprehensive Model (2020/21)
v. Supporting Early Cancer Diagnosis; (2020/21)
vi. CVD Prevention and Diagnosis; and (2021/22)
vii. Tackling Neighbourhood Inequalities (2021/22)

2.3 This was then supplemented with full details included in the publication of the Network Contract DES Contract Specification for 2019/20[4] which commenced on 1st July 2019.

2.4 It is important to note that every practice has the right to join a Primary Care Network in its CCG, but the Network Contract DES remains voluntary. In the event that a practice does not want to sign-up to the Network Contract DES, its patient list would need to be added into one of the local Primary Care Networks to ensure all patients have access to network services. That PCN would then take on the responsibility of the Network Contract DES for the patients of the non-participating practice through a locally commissioned agreement.

2.5 The Network Contract DES for 2019/20 includes the following requirements for PCNs:

2.6 **To appoint a named accountable Clinical Director** who will provide leadership for the PCN's strategic plans, working with members to improve the quality and effectiveness of the network services. This role can be job-shared, but a Clinical Director must be a registered clinician working in a practice within the PCN. The key responsibilities of the Clinical Director include:

- Providing strategic and clinical leadership to the PCN, developing and implementing strategic plans, leading and supporting quality improvement and performance across member practices (including professional leadership of the Quality and Outcomes Framework Quality Improvement activity across the network). The Clinical Director would not be solely responsible for the operational delivery of services; this will be a collective responsibility of the PCN.

- To provide strategic leadership for workforce development, through assessment of clinical skill-mix and development of a PCN workforce strategy.

[4] Network Contract Directed Enhanced Service Contract Specification 2019/20 published in April 2019 https://www.england.nhs.uk/wp-content/uploads/2019/03/network-contract-des-specification-2019-20-v1.pdf

- To support PCN implementation of agreed service changes and pathways and work closely with member practices and the commissioner and other networks to develop, support and deliver local improvement programmes aligned to national priorities.

- To develop local initiatives that enable delivery of the PCN's agenda, working with commissioners and other networks to reflect local needs and ensuring initiatives are coordinated.

- To develop relationships and work closely with other Clinical Directors, clinical leaders of other primary care, health and social care providers, local commissioners and LMCs.

- To facilitate participation by practices within the PCN in research studies and will act as a link between the PCN and local primary care research networks and research institutions.

- To represent the PCN at CCG-level clinical meetings and the ICS/STP, contributing to the strategy and wider work of the ICS/STP.

2.7 **To have in place appropriate data sharing arrangements** for both clinical and non-clinical data, including read/write access to patient records so that a GP from any practice within the network can refer, order tests and prescribe electronically and maintain a contemporaneous record for every patient.

2.8 **To recruit the additional workforce available in 2019/20 including** a 1.w.t.e. Clinical Pharmacist (70% reimbursement) and 1 w.t.e. Social Prescribing Link Worker (100% reimbursement); however, neither role is mandatory.

2.9 **To provide extended access hours** (30 minutes per 1000 registered patients per week) across the PCN in addition to the CCG commissioned extended access service.

2.10 The table below outlines the payments to be made to PCNs under the terms of the Network Contract DES.

Payment details	**Amount**
PCN funding	£1.50 per registered patient per year
Clinical Director contribution (population based payments)	£0.514 per registered patient to cover July 2019 to March 2020
Additional Roles	Actual costs to the maximum amounts

• Clinical pharmacists • Social prescribing link workers	per the Five-Year Framework Agreement, paid from July 2019 following employment
Extended hours access	£1.099 per registered patient* to cover period July 2019 to March 2020

*The full year funding under the Network Contract DES equates to £1.45 per registered patient per annum. In 2019/20 the funding cover quarters 2 to 4 and therefore equates to £1.099 per registered patient.

On top of this payment of £1.45 per registered patient per annum through the Network Contract DES, practices will receive within their global sum payments around £0.50 per patient to cover the expansion in delivery to 100% of patients. Taken together, the two amounts would total a payment of approx. £1.95 (£1.45 plus £0.50) per registered patient per year.

2.11 In addition to the payments made to the PCN's nominated payee under the terms of the Network Contract DES, practices participating in the Network Contract DES will be entitled to the **Network Participation Payment**. This payment equates to £0.147 per weighted patient and is payable from July 2019 following a GP practice's sign-up to the Network Contract DES.

3. Formation of Sandwell and West Birmingham CCG Primary Care Networks

3.1 In determining the formation of PCNs the following national rules were stated in the Network Contract DES:

3.2 Each Primary Care Network must have a boundary that makes sense to:

a) its constituent practices
b) to other community-based providers, who configure their teams accordingly
c) to its local community, given it marks the extent of PCN accountability for the health and wellbeing of a defined place.

3.3 NHS England also confirmed that there would be no requirement for PCNs to stay within Local Authority Boundaries, but that there would be an expectation that PCNs would not normally cross CCG, STP or ICS boundaries. However, there was also recognition that there may be exceptions to this such as where the practice boundary, or branch surgery, crosses the current CCG boundaries.

3.4 Therefore, SWB CCGs Primary Care Commissioning Committee also agreed a series of local principals:

a) Each PCN should not span 2 Local Authorities, 2 Community Nursing Providers or 2 Mental Health Trusts. The rationale for the above is that PCNs forming in 30,000 – 50,000 populations enables the provision of proactive, accessible, coordinated and more integrated primary and community care, improving outcomes for patients. 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. Mitigation to this may be that the PCNs have worked with both Community Trusts to discuss and agree any changes. Some practices are historically covered by BCHC and SWBHT community nursing services.

b) Birmingham and Solihull CCG and SWBCCG agreed in principle that where necessary practices from either CCG would be allowed to join a PCN in either CCG. The rationale for this is that in the West Birmingham area, the practices are so densely clustered together due to the density of the population that it may be better that practices can work together in a coterminous area.

c) Support the PCNs where practices can justify and give sustainable evidence for being together in a PCN even though it may not be a coterminous geography This is in particular for West Birmingham PCNs. As West Birmingham spans multiple practices across SWBCCG and BSOL, CCG – donuts may appear where other BSOL Practices may be present.

d) All PCNs need to assure the CCG they have undertaken a robust of process to agree their Clinical Director and that all practices are in support of the leadership person in this role.

e) Make an exception to the national rules, where necessary that a PCN can absolutely justify there is a need to do so and is supported by the GPFV Clinical Leads, CCG officers and the LMC.

f) Where there may be a lone practice that is not part of a PCN and wants to be, CCG officers to work with the LMC to resolve this and ensure that one PCN geographically takes on the practice.

3.5 A total of 15 Primary Care Networks were approved by our Primary Care Commissioning Committee in May 2019 and the current configuration of these is included in the table below:

NHS
Sandwell and West Birmingham
Clinical Commissioning Group

Sandwell PCNs	Code	Practice	Actual List Size As at 01.01.19	Total List Size As at 01.01.19
Caritas CD: Dr Laura Pugh	***M88006***	***Cape Hill MC***	***12017***	26741
	M88647	Rood End Medical Centre	3842	
	M88645	Hill Top Medical Centre (Dr Hanna)	10882	
Citrus Health CD: Dr Arun Saini	M88016	The Practice, Old Hill Medical Centre	1928	30700
	M88026	Portway Family Practice	4266	
	M88043	Haden Vale Surgery	6299	
	M88013	Black Country Family Practice	14232	
	M88031	Hawes Lane Surgery	3975	
Newcomen & Health Primary Care Network CD: Dr Ray Sullivan	M87013	Horseley Health Surgery	11372	29924
	M88600	The Victoria Surgery	3025	
	M88612	Glebefields Surgery	4112	
	M88030	Church View Surgery	6256	
	M88643	The Spires Health Centre	5159	
Your Health Partnership PCN CD: Dr James Gwilt	M88004	YHP Regis Medical Centre	45992	55326
	Y02701	Great Bridge Health Centre	9334	
Sandwell Primary Care Doctors CD: Dr T. Rahman	M88001	Village Medical Centre	7355	32152
	M88008	Stone Cross Medical Centre	5659	
	M88010	Swanpool Medical Centre	8998	
	M88022	Jubilee Health Centre	4216	
	M88023	Crankhall Lane Medical Centre	3725	
	M88627	Jubilee Health Centre	2199	
Together4Healthcare PCN CD: Dr K Rana	M88009	Victoria Health Centre (Norvic Family Practice)	9198	40626
	M88019	Bearwood Road Surgery	2199	
	M88035	New Street Surgery	3199	
	M88036	*Dartmouth Medical Centre*	3379	
	M88038	Linkway, Lyng Centre for Health	10510	
	M88610	Saraphed Medical Centre	3891	
	M88619	Lyng Centre for Health	8250	
Central Health Partnership CD: Dr Raminder Sawhney	M88014	Hill Top Surgery	4645	41051
	M88044	WBPFH Oakwood Surgery	3966	
	M88616	GBPFH Sai Surgery and Cordley Street	11441	
	M88626	Dr Haque's Practice, Primary Care Centre	2208	
	M88628	Cambridge Street Surgery	3016	

	M88629	Hill Top Medical Centre (Dr Hassouna)	2020	
	M88007	Oakeswell Health Centre	9552	
	M88633	The Surgery, Lodge Road	4203	

United Healthcare Network CD: Dr Suman Chawla	M88040	St Paul's Surgery	7637	37759
	M88620	Causeway Green Surgery	2568	
	M88630	The Surgery, Clifton Lane	5747	
	M88630	ST PAUL'S PARTNERSHIP - Lyng Medical, Lyng Centre for Health	5747	
	M88042	Bearwood Medical Centre	4526	
	M88640	Warley Road Surgery	3265	
	M88041	Hawthorns Medical Centre	3471	
	M88646	Dr Dewan	1930	
	M88639	Dr Pathak's Surgery, Primary Care Centre	2868	

Oldbury & Langley PCN CD: Dr Basil Andreou	M88635	Dog Kennel Lane Surgery	1888	34723
	M88003	Warley Medical Centre	11312	
	M88018	Dr Andreou & Partners (Oldbury Health Centre)	19205	
	M88618	Walford Street Surgery	2318	

Pioneers for Health – Sandwell (North) CD: Dr Rajiv Kalia	M88015	Great Barr Group Practice	9947	21359
	M88021	Drs P Pal & S Jemahl	5924	
	M88024	The Surgery, Sundial Lane	3071	
	M88623	Park House Surgery	2417	

West Birmingham PCNs	Code	Practice	Actual List Size As at 01.01.19	Total List Size ACTUAL As at 01.01.19
Modality PCN CD: Dr Gwyn Harris	M85002	MODALITY Handsworth Wood Medical Centre	22845	73563
	M85069	MODALITY Laurie Pike Health Centre	17754	
	M85178	MODALITY Enki Medical Practice	10728	
	M88002	MODALITY The Smethwick MC	8936	
	M85124	MODALITY Bellevue	11374	
	M85085	MODALITY Ann Jones Family HC	1926	

Pioneers for Health West Birmingham (South) CD: Dr Sonul Bathla	M85684	City Road Medical Centre	2221	39352
	M85715	Soho Health Centre GP & Yellow Fever Travel Centre, Soho Health Centre	10437	
	M85721	Holyhead Primary Healthcare Centre	8602	
	M85797	Hockley Medical Practice	8437	
	M85176	Kirpal Medical Practice,Soho Health Centre	4607	
	Y00412	Dr Bhalla's Practice, Soho Health Centre	5048	

Pioneers for Health West Birmingham (Central) CD: Helen Kilminster (clinical pharmacist) and Dr Manish Latthe	M85009	Hamstead Road Surgery	5753	35442
	M85019	Tower Hill Partnership Medical Practice	17553	
	M85082	Handsworth Medical Practice	3897	
	M85145	The Surgery, The Slieve	6738	
	M85801	Holly Road Surgery	1501	

I3 PCN CD: Dr Samar Mukherjee, Dr Inderjit Marok	M85098	Rotton Park Medical Centre	5219	51691
	M85020	Newtown Health Centre	18696	
	M85634	Heathfield Family Centre	7773	
	M85676	Victoria Road Medical Centre	4819	
	M85697	Church Road Surgery	4467	
	M85757	Saini and Saini - Soho Medical Services, Soho Health Centre	3184	
	Y00492	Summerfield Group Practice	7533	

Urban Health PCN CD: Dr Imran Zaman	Y00471	Broadway Health Centre	4028	37192
	M85164	Newport Medical Practice	10309	
	M85778	Halcyon Medical Centre	10132	
	Y06378	Heath Street	5967	
	M85663	***[Bloomsbury HC - patient list currently being dispersed; patients being managed by Ridgacre Medical Centres until 31.03.20]***	**2919**	
	M85064	***[Five Ways MC - Patient list currently being dispersed; patients being managed by Broadway Health Centre until 31.03.20]***	***3837***	

3.6 It should be noted that one of our Sandwell PCNs (Caritas) has a member practice from BSOL CCG, Cape Hill Medical Centre.

3.7 This was agreed with BSOL CCG and we are working closely with them to ensure delivery against the Network Contract DES. For clarity the contractual responsibility for Cape Hill Medical Centre's GMS contract remains with BSOL CCG.

3.8 Whilst the membership of our PCNs has remained stable during the first year of the Network Contract DES, we are aware that there are currently ongoing discussions between the members of Pioneers For Health West Birmingham (South) around the future of their network with the likely outcome being a split in the membership. We are working with the network to ensure any changes can be put in place before the 1st April 2020.

4. Network Development

4.1 Prior to the nationally commissioned Network Contract DES, SWB CCG took the decision to invest £1 per patient into the formation and development of PCNs in March 2018, in anticipation of the national drive towards PCN development. Concurrently, an additional 50p per patient investment was made for PCNs to develop a workforce strategy, the requirements of which are contained in appendix 1 of this report.

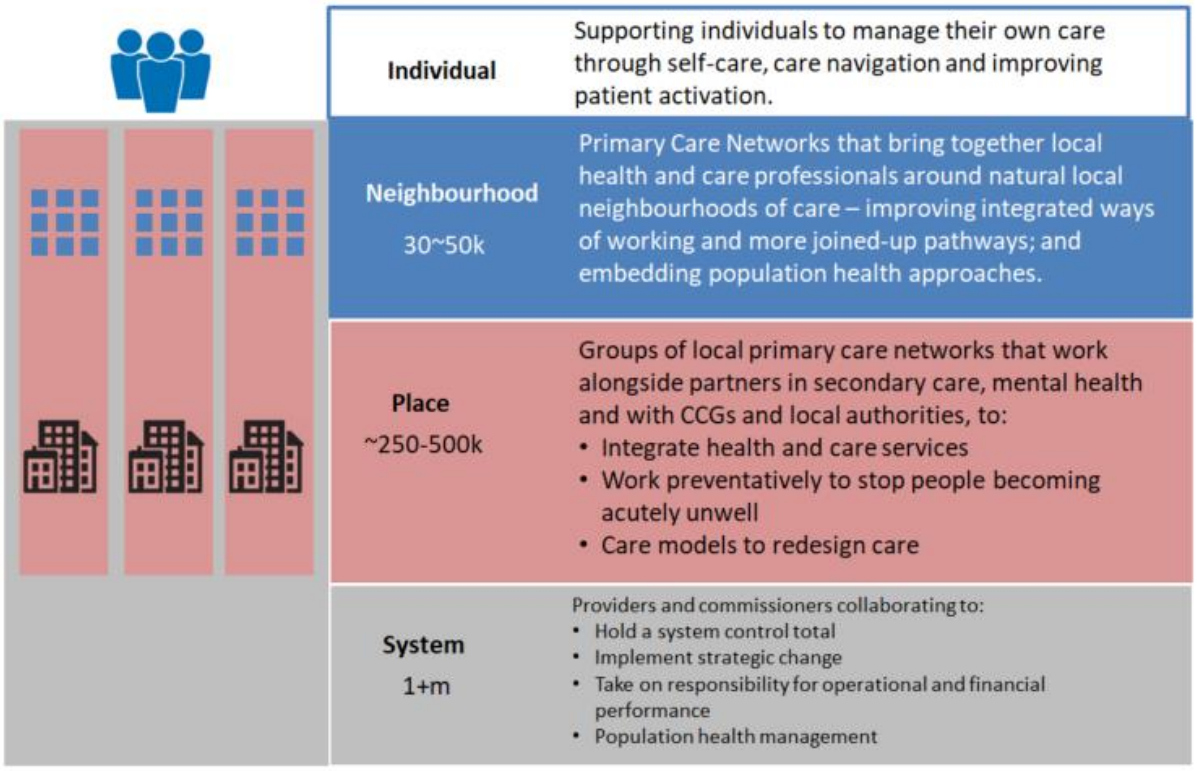
4.2 Following the above, PCNs have subsequently been supported by:

- CCG Primary Care Development Managers practice portfolios aligned to PCNs;
- Monthly CDs and PCN leads meetings;
- PCN leadership development (summer 2018);
- Two legal advice sessions;
- Support to release time for practices to work as PCN-based Action Learning Sets under the NHS England Releasing Time for Care Programme;
- PCN-focused Protected Learning Time event (April 2019);
- Investment into delivery of bespoke organisational development sessions for individual PCNs;
- An additional 50p per patient was invested in 2019-20 into a PCN Maturity Local Improvement Scheme (LIS), which can be found in Appendix 2;
- In quarter 4 2019-20, investment made available to free up additional clinical or non-clinical leadership capacity ahead of the launch of the national service specifications, and to support networks to implement PCN-specific schemes to increase collaborative working.

4.3 The intention of these initiatives was to provide networks with an opportunity to accelerate their development and place themselves in the best possible position to deliver the requirements of the DES over the full five-year duration of the contract.

5. Primary Care Network's and the wider Integrated Care System

5.1 NHS England have suggested that PCNs will operate at all three levels of the wider Integrated Care System:



5.2 **Neighbourhood -** At the neighbourhood level primary care networks will collaborate around natural geographies to improve general practice resilience, share staff and assets, and provide proactive, multidisciplinary care to populations of 30,000- 50,000. This is widely recognised as the scale to integrate community-based services and to provide multidisciplinary care for people with enduring, complex health and care needs, who require close collaboration between service providers and long-term care coordination.

5.3 As such, a key focus for PCNs should be on the development and implementation of network-level care models that improve access for episodic care, encourage self-care and support greater patient activation and wellbeing, as well as providing improved anticipatory care for those patient groups with rising risk profiles.

5.4 Examples of services that could be delivered at neighbourhood level:

- Extended Access Health trainers / peer coaches
- Proactive planned MDT care for complex needs, e.g. frailty Primary Care Diagnostics
- Care Navigators Minor operations

- Mental Health LTC IAPT workers Community Paediatrics
- Social Prescribing First contact practitioners for MSK conditions
- Substance Misuse Podiatry
- Urgent home visiting service Optometrist for eye health triage
- Care home outreach services

5.5 **Place -** At the place level, often coterminous with district/borough councils, primary care is frequently represented by large-scale general practice organisations (e.g. Federations, super-practices). These organisations make shared operational systems possible, whilst also enabling support in areas such as training, workforce development and quality improvement.

5.6 This is also the level at which primary care should seek to work with acute providers, mental health and local government to affect the development of place-based strategies and wider integrated care models. Engaging in this way with wider health and care partners will help to ensure that PCNs are embedded in the wider transformation of hospital-based services (e.g. U&EC and planned care), as well as being effectively positioned to influence and facilitate the shift towards more community-based models of care delivery.

5.7 Examples of services that could be delivered at place level:

- LTCs: Other:

  – Quarterly MDT Educational Meetings (Diabetes, Respiratory) – Extended and Urgent GP Access

  – Direct 111

  – Respiratory Specialist Outreach Support Team (Specialist GP, Consultant, Respiratory Specialist Nurse)

- Out of Hours

- Clinical/Virtual Hubs

  – MSK – Ambulance non-conveyancing

  – Advance Care Planning – Direct A&E booking

  – Access to Crisis and Recovery Teams – Specialist clinics

  – Intermediate care beds

  – UTC

5.8 For Western Birmingham, SWB CCG PCNs do not cover the entirety of the population with PCNs under BSOL CCG covering an estimated 25% of the population. Whilst PCNs from both CCGs work with many of the same providers at a place level the main difference is the acute provider that the majority of the PCNs patients are referred to. In this context, PCNs are under two distinct Integrated Care System footprints, with the West Birmingham PCNs from SWB CCG being members of a West Birmingham Integrated Care Partnership which includes, Sandwell and West Birmingham Hospitals NHS Trust, Birmingham Community Healthcare, Birmingham and Solihull Mental Health NHS Foundation Trust and Birmingham City Council and the Sandwell PCNs being members of a Sandwell Integrated Care Partnership which includes Sandwell and West Birmingham Hospitals NHS Trust, Black Country Partnership NHS Foundation Trust and Sandwell MBC.

5.9 **System -** At system level primary care functions are the foundation of a wider integrated care system, which works in partnership with other health and care providers to collaboratively manage population health, implement strategic change, take on added responsibility for operational and financial performance, and hold system accountability. There will be a strong focus on monitoring and evaluating PCN implementation/maturity with regional colleagues, and close working with constituent CCGs on the commissioning strategy for primary care, including design of future local business models and market development opportunities for PCNs.

5.10 Services in scope for delivery at 'System' level:

- All health and social care for the population, via local providers working with commissioners.

APPENDIX 1

PCN Workforce Strategy

As per the 'PRIMARY CARE NETWORKS: Memorandum of Understanding (MOU)' signed by Practices you agreed to:

- *Contribute towards and help produce a [Primary Care] Network 5 year workforce strategy that sets out the networks workforce challenges and how working collectively they will be addressed;*
- *actively support the development and delivery of the place based transformation programme, support the establishment of the Primary Care Network approach within their group, support the development of their Network primary care workforce strategy, attend network and partnership meetings, lead on specific areas of development as agreed within their group and review the needs of their registered population to feed into the wider partnership approach;*
- *work at scale, sharing workforce and infrastructure to improve patient care;*
- *practices shall be paid a onetime payment of £0.50 per head per patient in order to develop a 5 year workforce strategy collectively with their Primary Care Network partner practices. Implementation of the strategy will be over the course of 5 years commencing October 2018.*

Submission

We have revised submission of the draft headline plan to **November 30th 2018**, with full plan due for delivery March 2019.

Workforce plan questions to consider

To achieve meaningful workforce planning the following questions set by National Association of Primary Care (NAPC) in their guidance on 'Primary Care Home: population health-based workforce redesign' http://napc.co.uk/wp-content/uploads/2017/11/PCH-Workforce-redesign-booklet.pdf

- What are the needs of the local population? Are you clear about your local populatio n health challenges?
- Having determined local needs, what care does the population group require?
- Thinking about your current and future workforce, have you looked beyond the traditional organisations to identify and engage all the people delivering health and care services?

- Who will you need to deliver the required service changes?
- Are you clear about what you want your future transformed workforce to look like, their capability, and the services they will be providing?
- Have you done enough to understand the current and future demands on your existing workforce as well as where you are going to source them in the future?

Process:

To gain a clear understanding of what practices need for their workforce over the coming years, data needs to be collected from each practice site within the PCN. This data is to be collected on the provided 'workforce data collection excel spread sheet' (extra guidance on this is in section 1 below) in tabs under the following headings : Practice information, Services offered, Non-patient facing work done by clinicians, Clinical job roles, Clinics run by the practice, Non-clinical job roles, Clinical workforce, Non-clinical workforce, Vacancies.

For ease of data collection and analysis, where possible we have tried to pre-populate likely answers to the questions asked in the workforce data collection excel spread sheet, with drop down boxes but there will be a large degree of variation between the member practices (from smaller, possibly single-handed to larger, multi-partner practices). Therefore to get an accurate picture you will need to use the free text boxes. **E.g. tab 2 for services offered – In a single handed practice the Senior Partner maybe the only regular GP, hence they might have longer appointments than the normal 10 minutes but they may address a lot of extra services (QoF and PCCF) during that time. In larger practices this extra work might be done within different appointments by other members of the team, or in a specific clinic just for that one condition.**

For guidance the 'workforce data collection for PracticesOct-18 (example)' Excel file has some examples (in grey) of how to answer the questions.

Data needs to include a clear explanation of what services are offered, what duties are carried out, and who does them currently and what their future career plans are, as well as the current vacancy position.

This data will help develop a plan (PCN Workforce Strategy) on how the PCN's can help practices and how the CCG can help the PCNs, to help support practices to continue to provide the services and level of care they currently provide despite the challenges we are facing in workforce.

The PCN's are to then analyse this data to help them formulate a Workforce Strategy for the next 5 years. The PCN is to answer the questions below in sections 2 and 3 when they complete the data analysis. This list of questions for the PCN to complete is not an exhaustive list and PCNs can add extra questions to it to help formulate the Workforce Strategy as they feel is appropriate for their practices.

Below you will find:

Section 1) Workforce Data Collection for Practices: Guidance on how to complete the workforce data collection excel spread sheet

Section 2) Work force analysis: Questions for PCN's to complete

Section 3) Work force Plan: Questions for PCN's to complete

Section 1) Workforce Data Collection for Practices: Guidance on how to complete the workforce data collection excel spread sheet

The Practice are to complete the workforce data collection excel spread sheet with PCN support

Work force data collection is to be completed on the 'workforce data collection for Practices Oct-18 (TEMPLATE)' Excel spread sheet – networks may wish this to be completed by practices individually or with centralised network support.

The 'workforce data collection for Practices Oct-18 (TEMPLATE)' Excel spread sheet is to be completed for each individual site including branches as best fits the workforce deployment of the practice or partnership. This information will need to be shared with the PCN.

There are 8 tabs (worksheets) to be completed on the template:

1 Practice information

2 Services offered

3 Non-patient facing work done

4.1 Clinical job roles

4.2 Clinics

4.3 Non-clinical job roles

5.1 Clinical workforce

5.2 Non-clinical workforce

6 Vacancies

In addition there is a tab marked 'overview' summary which pulls together some of the key information about the practice; and a tab called Workforce summary which pulls together key information about the overall practice workforce.

Guidance notes on how to complete each tab on the workforce data collection excel spread sheet:

1 Practice information

Collate essentially data about the practice size, what training it supports etc.

2 Services offered

a) Describe the clinical services you run in the Practice on tab 2 on the spread sheet.

b) Describe any services offered in collaboration with other Practices on tab 2 on the spread sheet.

c) List each type of appointment or clinic/review/service offered, who delivers it and what they involve (each service might have more than one type of clinician doing them and vice versa) using the questions in the columns in tab 2 on the spread sheet.

Please be aware that some services do not fit perfectly into the questions or might give an inaccurate impression of the work done, hence the need to use free text boxes. E.g. in smaller Practices the clinicians might have longer appointments as they will be doing all services in one appointment (for example acute problems, chronic disease, and QoF and PCCF etc.).

It may not be possible to quantify time taken for every activity of work e.g. about of time spent doing travel imms, in which case use the 'if unable to quantify time spent please give explanation' box.

3 Non-patient facing work under-taken by clinicians

a) Describe the non-patient facing work done by clinicians in the Practice on tab 3 on the spread sheet.

b) Describe and any services offered in collaboration with other Practices on tab 3 on the spread sheet.

c) List each type of non-patient facing work under-taken by clinicians, who delivers it and what they involve by completing the columns in tab 3 on the spread sheet.

4.1 and 4.3 Different types of job roles within the Practice (Clinical and Non-clinical)

a) Describe if any staff are shared with other practices on tab 4.1 and tab 4.3 on the spread sheet.

b) List the different job roles (clinical – tab 4.1 and non-clinical – tab 4.3) in the Practice, length of appointments for clinicians, and number of people doing those roles etc. by completing the columns in tabs 4.1 and 4.3 on the spread sheet.

4.2 Different types of clinics within the Practice

a) Describe the different types of clinics you have on tab 4.2 on the spread sheet.

b) Describe any services offered in collaboration with other Practices on tab 4.2 on the spread sheet.

c) List the clinics you currently have in the Practice with details about them by completing the columns in tabs 4.2 on the spread sheet.

Some practices may only offer normal GP and nurse appointments and may not offer specific clinics for specific conditions.

5.1 and 5.2 Current work force

a) Does the Practice currently think it has enough staff for all areas of clinical and non-clinical work? Mark 'yes' or 'no' on each of tabs 5.1 and 5.2 on the spread sheet.

b) Describe why do why the practice think this is on tab 5.1 or 5.2 on the spread sheet.

c) Enter information for each member of staff; this information covers duties, length of service, intention to leave service if any, hours worked etc.

Column A – 'identifier' asks practices to use a number and/or letter identifier that the practice and PCN can use to identify which staff the template has been completed for. We would suggest the same 'key' is used for each practice in the PCN. Please delete any information in column A before sending the spread sheet back to the CCG.

To collect this information you may wish to gather this information at either Practice or PCN level, and PCNs may find it useful to get external help.

6 Vacancies

Please record each current vacancy and its respective number of hours here.

Section 2) Work force analysis
Questions for PCN's to complete

PCN's will need to collate and complete a meaningful analysis of data in order to help draw up a work force plan.

The headline details of this plan along with the 'workforce data collection for Practices Oct-18 (TEMPLATE)' Excel spread sheets should be completed and submitted by the end of November 2018, with the full plan completed by March 2019 – however, as circumstances will change, PCNs are encouraged to continue to develop their plans.

a) After analysing the data PCN's are to provide a detailed **summary of their workforce analysis across the PCN** i.e. what practice needs have been identified, how are things now and how will things look in 5 years if nothing changes? Are there common themes? What are Practices across the PCN are planning to do?

b) Detail how the demand for services and services offered is likely to change across the PCN over the next 5 years:

Section 3) Work force Plan
Questions for PCN's to complete

i) Future work force needs

a) Detail the changes that will need to take place in workforce across the PCN over the next 5 years?

b) Detail how this is to be achieved by the PCN:

ii) Future workforce planning

a) What challenges have been identified? E.g. retirement of GP's and nurses, reduced GP and nurse entering or staying in the profession, recruitment etc…

b) How will the PCN address these?

c) Which services offered by member Practices can be offered together as a group and how will the PCN do this?

d) Which services offered currently can be offered by different disciplines and how will the PCN do this?

e) Which job roles/duties can be shared within a PCN and how will the PCN do this?

f) How could the work force change across individual Practices and across the PCN over the next 5 years?

APPENDIX 2

Primary Care Network Maturity
Local Incentive Scheme (LIS)

1st April 2019 to 31st March 2020

1. Introduction

This Local Incentive Scheme outlines the requirements for accelerating the development of Primary Care Networks, placing them in the strongest position internally as GP Networks and as a key player in the wider Primary Care Network and place based alliance with other provider partners and the voluntary sector.

2. Background

Refreshing NHS Plans for 2018-19[5] set out the ambition for CCGs to actively encourage every practice to be part of a local primary care network. This was then cemented through the NHS Long Term Plan[6] which stated 'as part of a set of multi-year contract changes individual practices in a local area will enter into a network contract, as an extension of their current contract, and have a designated single fund through which all network resources will flow'. It is clear from the NHS Long Term Plan that Primary Care Networks will be an essential building block of an integrated care system and therefore their development will be key to the successful functioning of this future system of care.

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 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. Networks will provide a platform for providers of care being sustainable into the longer term.

[5] NHSE/NHSI (9th February 2018) Refreshing NHS Plans for 2018/19
[6] NHSE (January 2019) NHS Long Term Plan

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

The publication of Investment and Evolution: A Five Year Framework for GP Contract Reform to implement The NHS Long Term Plan[7] translates commitments in The NHS Long Term Plan into a five year framework for the GP services contract with further detail around requirements for 19/20 included in the subsequent publication of the Network Contract Directed Enhanced Service contract specification, network agreement and guidance.

The first year of the Network Contract DES will be a development year, with the majority of service improvements being introduced from April 2020 onwards. We are therefore commissioning this PCN Maturity LIS to further accelerate the development of our local PCNs putting them in the strongest possible position to deliver the DES as it evolves over the five year period and also allowing them to become a strong player within the place based alliances currently in formation.

3. Nature of the Service

To accelerate the development of Primary Care Networks along the PCN maturity matrix networks will be required to deliver the following during 19/20:

PCN Maturity Matrix Requirement	Actions for PCNs
PCN Operational Efficiencies Step 1 – Steps taken to ensure operational efficiency of primary care delivery and support struggling practices	Workforce, Estates and IT are planned for at Network level and as part of the wider system to deliver sustainable and integrated care.

[7] NHSE and BMA (31st January 2019) A Five Year Framework for GP Contract Reform to implement The NHS Long Term Plan.

Step 2 - Functioning interoperability within networks, including read/write access to records, sharing of some staff and estate. **Step 3 -** Fully interoperable IT, workforce and estates across networks, with sharing between networks as needed	All practices within the network have fully interoperable IT with read/write access to records. Back office functionality and shared protocols and procedures are implemented across the PCN/Federation/Super Partnership to support managing demand at a practice level. Agreed workflow protocols are in place (either at individual practice or network level) to ensure optimisation of the processes for managing clinical correspondence. Office 365 is used to share all Network information, protocols and documentation with internal practice members. Opportunities for network level purchasing of goods or non-clinical services are identified and put into place.
Reducing variation in outcomes and resource use **Step 1 -** Analysis on variation in outcomes and resource use between practices is readily available and acted upon **Step 2 –** 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	Outcomes and resource use data is analysed on a monthly basis to enable internal network peer review. Develop and implement an action plan to reduce variation in outcomes and resource use across network practices Develop shared protocols for: • Same day access • PCCF delivery
Integrated Teams **Step 1 –** Integrated teams which may not yet include social care and the voluntary sector, are working in parts of the system **Step 2 –** Integrated teams throughout the system, including social care, voluntary sector and easy access to secondary care expertise.	Work towards the development of an agreed integrated care team across the network which includes practice staff and staff from community services, mental health, social care and the voluntary sector. Has agreed protocols for accessing secondary care expertise (e.g. DiCE clinics).
Population Segmentation and targeted interventions	Build on the basic population segmentation undertaken in 18/19 to develop systematic population health analysis, ensuring an in depth

Step 1 - Basic population segmentation is in place with understanding of needs of key groups and their resource use **Step 3 –** Systematic population health analysis allowing PCNs to understand in depth their populations' needs and design interventions to meet them	understanding of the network's population health needs. Document the health needs of each identified population segment and the services the network has in place (or is developing) to meet these needs through its single integrated team, including reference to services provided from other providers outside of the network of practices. To ensure a proactive approach is taken to managing the health needs of the population document the targeted interventions for each population segment. In conjunction with patients from within the network population, clinicians and managers should agree a set of priority services and outcome measures targeted at areas where the PCN is furthest from the national and/or local norm.
Models of Care **Step 1 –** Standardised end state models of care defined for all population groups, with clear gap analysis to achieve them **Step 2 –** Early elements of new models of care in place for most population segments **Step 3 –** New models of care in place for all population segments across system.	Work towards developing a logic model for each defined population group to identify an end state model of care, highlighting any current gaps that need to be met Develop and implement an action plan to meet identified gaps Suggested population groups/segments: Frail elderly Children (0-16 years) Mental Health Single Long Term Condition Multiple Long Term Condition Wellness population
Decision Making and Funding (Alliance Boards) **Step 1 –** Primary care has a seat at the table for system strategic decision making	Develop a united primary care voice across networks within the place to influence decision making at an Alliance Board level, with identified leadership representing all PCNs within the place. Formal governance for this should be decided on locally and supported by the CCG.

Step 2 – Primary care plays an active role in system tactical and operational decision making (for example on UEC) **Step 2** - Networks have sight of resource use and impact on system performance, and can pilot new incentive schemes. **Step 3 –** Primary care providers full decision making member of ICS leadership, working in tandem with other partners to allocate resources and deliver care **Step 3** - PCNs take collective responsibility for available funding. Data being used in clinical interactions to make best use of resources	Review the STP approved outcomes framework for the integrated care system and create a high level approach for delivery to the framework, linking this to the network's population segmentation and models of care. Work in partnership with neighbouring networks, public health, social services, acute, primary, community and mental health providers, the voluntary sector and commissioners to agree new care models and pathway development. Work with provider partners against the outcome measures.
PCN Business Model/Plan **Step 1 -** Practices identify PCN partners and develop a shared plan for realisation **Step 2 –** PCNs have a defined future business model and have early components in place **Step 3 –** PCN business model is fully operational	Have in place a PCN Business Plan which is formally refined on a quarterly basis and articulates: • The long term vision for the network • The governance structure and lead roles within the network (including the election process for selecting the Clinical Director and the formal agreement in place to support collaborative working across network practices). The Clinical Director will be accountable for delivery of the Network Contract DES and this PCN Maturity LIS and therefore this role must be reviewed annually and re-voted in each year • The terms of reference for the network including how each individual practice contributes to decision making • The role of the PCN patient participation reference group within the network • A shared plan for continuous quality improvement across all of the practices that form the PCN and at an integrated team level. This should include the PCN work programmes identifying clear roles and responsibilities, defined tasks and actions and timeframes to deliver on the agreed objectives (who, what, how, when) • How the network is sharing workforce and estates to deliver new care model service

	initiatives (including any future intentions around estates developments) • The organisational development plan for the network • The business continuity plan across all practices within the network, ensuring failing practices are supported by the PCN • The digital offer for patients • How extended access will be aligned at a network level To have in place by 31st July 2019 a robust workforce strategy which takes into consideration the new clinical roles for networks as part of the five year GP contract framework

4. Eligibility to Provide

The PCN Maturity LIS is open to all Sandwell and West Birmingham CCG PCNs who are signed up to and providing the Network Contract DES and will form a supplementary Network service.

5. Monitoring Arrangements

Primary Care Networks will be required to share the following evidence via Office 365:

- The PCN workforce strategy which takes into consideration the new clinical roles for networks as part of the five year GP contract framework by 31st July 2019.

- The overall PCN business plan covering as a minimum all of the areas detailed above. This should be a live document that is refined quarterly with the first iteration being shared by 30th September 2019.

- A statement (by 31st March 2020) of how the network has met each of the requirements listed under:
    - Operational efficiencies
    - Reduction in variation of outcomes and resources use
    - Integrated teams
    - Population segmentation and targeted interventions
    - Models of care
    - Development of Alliance working

6. Payment

This agreement covers the period 1st April 2019 to 31st March 2020.

Payment will be made to the nominated payee within the PCN at a rate of 0.50p per patient to deliver all elements included in section 3.

There will be no variation to the increase in the agreement value in year.

Payments are subject to the submission of a signed agreement

7. Termination

This agreement may be terminated by either party providing 3 months' notice in writing. Upon termination the full payment made to the PCN will be recovered.