

Primary Care Networks (PCN) - a GP's perspective – Blog No 4

These are not necessarily new to everyone, these structures have been evolving in many different areas and may be referred to as clusters, localities, neighbourhoods, natural communities of care or Primary Care Homes. To avoid confusion, I shall refer to them as a PCN because they are all examples of this.

The NHS is moving towards commissioning services and outcomes, based on populations. This means that in a defined population, you look at the current state of health and the health needs of that population then design, develop and implement services within that population that will have the greatest benefit. General practice has always been based on a defined registered population and is therefore well placed to be at the centre of this but cannot do this alone. The reason this is called a Primary Care Network rather than a GP Network is because it will involve health and social care professionals working together as a locally based multi-disciplinary team removing many of the existing barriers because they will be locally led and managed.

Are they an opportunity or a threat? If they have general practice at the centre and they have a feeling of ownership and play a significant role in the leadership, the PCN attracts new resources, is given existing resources to directly managed more effectively, and is given the freedom to implement change not only will they support general practice and the wider primary care team, they will also help to manage demand in primary care and by doing so start to address many of the demands on hospital based care.

If the NHS is serious about trying to address the challenges of an ageing population and growing numbers of people with one or more long term conditions and more and more people with preventable disease, it cannot achieve this by simply focusing on investing more and more resource in hospital-based care. The greater benefit for the NHS will be seen by developing and expanding services in the community.

The challenges for the NHS are often seen as the pressure on hospitals, defined by 4-hour trolley waits, outpatient waiting times, delays in elective operations and delayed discharges but rarely do you see the challenges faced by general practice and the wider primary care team covered. The NHS has described 'wrapping services' around patients, moving services 'closer to the patient's home' and supporting primary care by creating an 'integrated team', but how can that be achieved in reality?

General practice delivers holistic care, based on the needs of the individual and organises care around a registered population. The size of practices can vary considerably from 2,000 patients or less to an increasing number of practices who have a registered population of 30,000 or more working from several sites. The PCN is not about creating a network of single practices it is also about supporting small practices.

GP Practices provide the front door to many services within and forms the foundation of, the NHS. General practice is currently under considerable pressure and more needs to be done to support, sustain and develop not only general practice but the wider primary care-based workforce. We should also create other route to care so that they do not always need to go via a GP.

One of the many attributes about general practice is its ability to innovate, drive change and implement at pace with the minimum of bureaucracy. We know that general practice is responsible for 90% of the daily patient contacts within the NHS, therefore if you want to develop a greater focus on population-based care you need to have general practice at the centre of it and for GPs to have a leadership role within this.

Size is important but needs to reflect local circumstances. We know through the work that the Primary Care Home has led, that geographical populations of about 30 – 50,000 works well, as it is small enough for those involved to feel a sense of community and responsibility for their local population but also large enough to work as a 'delivery unit' that can have real influence in the health and social care system. For some places the size might be less than a population of 30,000 and for others they might be larger than 50,000.

Primary Care Networks are not statutory bodies or formal organisations. They are a network of providers collaborating, working as a 'delivery unit' providing the vehicle to support general practice, integrate local services and develop and deliver services that would support the wider community. At the centre of the PCN must be the constituent practices, who feel a sense of ownership and also benefit, without them this will not work. This does not require practices to merge, simply to collaborate together for the benefit of all their patients. There could be additional advantages in terms of joined up CQC policies, centralised management of back office functions, increased buying power.

Within a PCN there needs to be a leadership team that should include GPs, Managers, Nurses and may include other relevant people. There are services which should be delivered at a network level and have a presence in every practice for example a team of Pharmacists, Care Navigators, Mental Health Nurses, Community Nurses, a wound care team. These services may not be delivered at an individual practice level, but they should be working with and for practices.

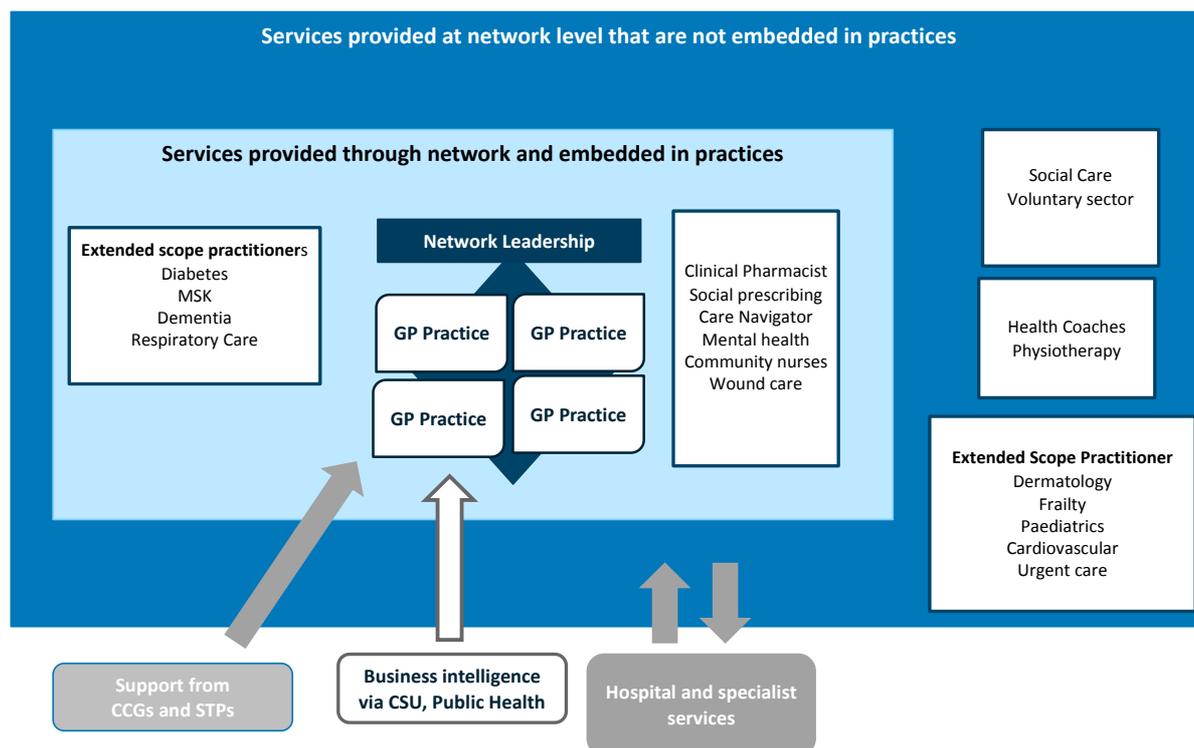
An essential component to deliver this is the use of a shared patient record which has been shown to improve efficiency, stop duplication, reduce the administrative burden and improve patient safety. Some services could be delivered at the population of a network with the network leadership team having responsibility for the delivery such as physiotherapy, health coaches, 'tier 2' dermatology, Frailty, etc.

These services may be responsible and accountable to the network but does not necessarily have to be employed by them. We know that culture and relationships are vital to any organisation being effective, the PCN will bring together clinicians and others who no longer meet together on a regular basis, if at all, and that the strength of this would be built on people feeling part of a common team with common goals.

A PCN has the potential to improve quality and gain efficiency. The PCN must support general practice in terms of workload and expanding the workforce it will then help with recruitment and retention, making general practices more resilient and a better place to work.

Working at scale: Primary Care Networks

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The potential for the network is significant and but can limited by the constraints that the system places on it. The system must not only support PCNS BUT WILL NEED TO WORK CLOSELY WITH THEM.

No two Primary Care Networks will look or perform in the same way but below are some potential examples.

Community Nursing – working for the network, based in practices but working at the network population level. Using a single record with the practices, accountable to the network leadership team. A new set of outcome measures looking at the network population needs to be developed.

Home Visiting – this could be achieved by practices working together, supported by Nurse Practitioners and Emergency Care Practitioners. In some areas a home visiting service has been commissioned to support general practice and help meet the demands of the local population.

Frailty – one of the major challenges for the NHS is the ageing population, many who have more than one long term condition. These patients will have greater needs and most of these are best met by a multi-disciplinary team based in the community as the alternative is hospital-based care which is far more costly and may not address their needs in a holistic way.

Wound Care – community and practice team create a wound care team which ranges from an HCA removing sutures and working with the nursing team to manage leg ulcers or simple dressings to a complex wound care service – e.g. ‘Lindsay Leg Club’ with some in-put from the Tissue Viability Nurse.

Pharmacy Team – the practice-based team will include an experience pharmacist who is a prescriber, and then may have newly qualified pharmacists who work with the experienced pharmacist. This team would then work with the GPs, practices, community pharmacist and also hospital pharmacists. Reducing polypharmacy, managing medication queries, helping with repeat prescribing and increasing the uptake of electronic prescribing, managing some long-term conditions, ensuring patients discharged from hospital are prescribed the correct medication on an ongoing basis. Some CCGs have invested in a prescription POD (Prescription Ordering Direct) which works on behalf of practices and manages most of the repeat prescription requests, dealing directly with patients.

Diabetes Team – based in the network, with a team made up of extended scope GPs, Trainees, specialist nurses and lead by a specialist who would cover a population that is greater than one network. Care plans made in patients records, negating the need for referrals etc.

Paediatric Hub – being implemented in Hampshire, monthly clinics based in general practice with a lead consultant, GP with an interest who could become an extended scope practitioner and at the end of the clinic, potential for an MDT meeting with whoever wanted to engage with the team. Direct booking for GPs and records made on patient record.

Access – currently there is extended opening, delivered at practice level and improving extended access delivered at a larger population level. The improving extended access is funded via the GP Forward View at £6 per patient. This funding could be offered to networks who are then responsible for delivering better access across their population and reflecting the local need. This might involve more than one network working together to meet the demand for example at weekend or where a network is unable to deliver the service. Federations may also be an organisation that can deliver this service at scale.

Mental health – this is one of the priorities for the NHS. It is also one of the clinical areas where the workload in general practice could be supported by suitably trained and skill staff. For example, CPNs working across general practice and the community mental health service.

For children and older people services could be focused at a population level and work more closely with the emerging networks. For example, Dementia advisors and nurses based in a network but also working with the specialist teams.

Health Coaches – available in some areas, aim to de medicalise care, help people to care for themselves and find different ways of supporting individuals. These could be based in a network.

Education and Training – the network can become a training hub and takes on some responsibility for apprentices, medical students, nursing students, paramedics, pharmacists etc. all of which attract new funding and start developing a pipeline for new staff in the future.

Voluntary Sector – one practice I visited have developed a community hub with regular voluntary sector/health promotion/social care clinics.

These are just examples of what could be possible and are currently established in different parts of the country. We have seen how these networks can not only benefit patients but can benefit the staff that work within them where this has created opportunity for new roles and has made recruitment and retention easier and this has also expanded the team that is supporting the GPs. The potential even in the more advanced areas is considerable.

We would expect the networks to get some business intelligence from CCGs, the Commissioning Support Unit (CSU) and Public Health.

As these delivery units are sufficiently large and cover well defined populations the local authority and hospitals will want to engage with them and potentially partner with them to develop services.

The networks will not develop unless they are given adequate resource and that will include protected time for those leading the network and support the development, given the authority and autonomy to make more efficient and effective use of some existing services and provided with new resources to develop and expand the workforce.

Networks already exist and are at different stages of maturing, each will need to be allowed time to develop and gain the support from the wider NHS. For networks to thrive they need to be supported by the Commissioners and not burdened with meetings and excessive reporting requirements. They need timely information both from Public Health and from Commissioners.

The benefits may not be realised in a matter of weeks or months but to gain the maximum benefit there does need to be a clear vision, incentives and some time and space to develop without annual changes in priorities or targets.

I believe that the workforce is one of the main issues facing most of us, but I'm convinced working as a team rather than in silos is part of the solution. Networks can also review training and workforce plans together and create a better place to work in and lead to a better environment for staff and patients.

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