Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

BNSSG Primary Care Commissioning Committee (PCCC)

Date: 28th January 2020
Time: 9.00am – 11.35am
Location: The Vassall Centre, Gill Avenue, Bristol, BS16 2QQ

Agenda Number :	7
Title:	Primary Care Network Update January 2020
Purpose: ~~Decision~~/Discussion/~~For Information~~	
Key Points for Discussion:	
• Primary Care Network Direct Enhanced Service Consultation Feedback -Key Points • Employment Models for PCN Additional Roles • PCN Leadership and Organisational Development Funds	
Recommendations:	To discuss: Network Contract Direct Enhanced Service Draft Outline Service Specifications Feedback to NHS England national team Employment Models for PCN Additional Roles PCN Organisational Development Funds
Previously Considered By and feedback :	Employment Models and PCN OD and Leadership Development Funds previously considered by Executive Team of BNSSG CCG on 18th December 2019. Feedback: Further information needed regarding a system leadership programme for Clinical Directors, and describe "what good looks like" to ensure additional funds enable PCNs to progress through the maturity matrix and support the development of our ambitions for integrated care in the Long Term Plan.
Management of Declared Interest:	All conflicts of interest are managed by PCCC on the Declaration of Interest Register. Members of PCCC may work in a PCN delivering Network DES, and accessing Leadership and OD funds.
Risk and Assurance:	If PCNs are not resilient they will be unable to deliver Primary Care plans. To mitigate this risk, actions have been put in place and are listed in this paper.

Financial / Resource Implications:	The CCG financial position is set out in section 4.
Legal, Policy and Regulatory Requirements:	The CCG will follow its procurement policies as appropriate in the mobilisation of the organisational development and leadership development plans for Primary Care Networks.
How does this reduce Health Inequalities:	PCNs are being supported in collaboration with Area Teams to ensure they deliver at locality level and PCN level depending on the population requirements of PCNs and localities to reduce health inequalities in BNSSG. The locally agreed action to tackle inequalities specification will come into effect from 2021.
How does this impact on Equality & diversity	There have been no implications for equality and diversity identified.
Patient and Public Involvement:	We are engaging with patients and the public as well as with professionals in the refresh of the primary care strategy and as part of this we have asked about the opportunities for Primary Care Networks in BNSSG and this will inform our development plan. The key messages have been about the opportunity for sharing and spreading resources and good practice across a wider population.
Communications and Engagement:	We are engaging with patients and the public as well as with professionals in the refresh of the Primary Care Strategy and as part of this we have asked about the opportunities for Primary Care Networks in BNSSG and this will inform our development plan. The key messages have been about the opportunity for sharing and spreading resources and good practice across a wider population. We held a workshop with Clinical Directors in October to shape the needs for an OD programme and we have held a teleconference with Clinical Directors to respond to the NHSE consultation for the draft new PCN specifications.
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Agenda item: 7

Report title: Primary Care Network Update January 2020

1. Primary Care Network Direct Enhanced Service Consultation-Key Points and Response to NHS England

1.1 Background

The GP Contract Framework was published in January 2019, and established the introduction of Primary Care Networks (PCNs). The GP contract framework set out seven national service specifications that will be added to the Network Contract DES: five starting from April 2020, and a further two from April 2021. Details of the draft five new service specifications were published by NHSE for consultation on 24th December and BNSSG CCG has submitted a collective response to NHS England following engagement with Clinical Directors (CDs) and the Avon LMC. The consultation closed on15th January 2020.

The PCN specifications will be delivered by Primary Care Networks (PCNs), in collaboration with community services and other providers, from April 2020. It is proposed that some of the services of the specifications will be delivered solely by General Practice working through the Primary Care Network contract and some (Enhanced Health in Care Homes and Anticipatory Care) in close partnership with providers of community services.

The five draft service specifications are:

- Structured Medication Reviews and Optimisation
- Enhanced Health in Care Homes (jointly with community services providers)
- Anticipatory Care (jointly with community services providers)
- Personalised Care; and
- Supporting Early Cancer Diagnosis

The NHSE proposal is that is that two of the five specifications will be delivered in full in 2020/21 (Structured Medication Reviews and Optimisation and Enhanced Health in Care Homes). The other specifications will be implemented in full by 2023/24.

1.2 Overview of proposed draft specifications

(i) Structured Medication Reviews (SMR) and Optimisation

It is expected that a number of GP appointments may be prevented when individuals have a proactive SMR: supporting the alleviation of workforce pressures on GPs and reducing the risk of harm to patients – an evaluation will be commissioned by NHSE in year one.

PCNs will identify people who would benefit most from receiving structured medication reviews. It is likely that Clinical Pharmacists will carry out these reviews, but could also be carried out by Advanced Nurse Practitioners and GPs.
From April 2020, PCNs will identify a clinical lead who will be responsible across the PCN for the delivery of the service requirements. A clinical lead within the PCN is required for the delivery of each service specification

(ii) Enhanced Health in Care Homes (jointly with community services providers)

Vanguard sites across the country have found the needs of patients are better met by enhanced health care in care homes and there are fewer impacts on the system (e.g. urgent care) with this approach. Delivery of this specification must happen in partnership between general practice and community services. The proposed Standard Contract requirements will ensure a contractual basis for the requirements attributable to community service providers, and CCGs will oversee local agreements between providers within a PCN to ensure that primary and community care are supported in delivery by relevant partners being held to account.
CCGs will be asked to support delivery of this service by holding a list of care homes in the area and agreeing the responsibilities of PCNs in relation to each home, ensuring each care home is aligned to a single PCN. These discussions will form part of contract negotiations. Due to the geographical distribution of care homes, PCNs will be affected differently. NHS England is considering this issue further and will provide further clarification.

(iii) Anticipatory Care

Anticipatory care helps people to live well and independently for longer through proactive care for those at high risk of unwarranted health outcomes. Typically, this involves structured proactive care and support from a multidisciplinary team (MDT). It focuses on groups of patients with similar characteristics (for example people living with multi-morbidity and/or frailty) identified using validated tools (such as the electronic frailty index) supplemented by professional judgement, refined on the basis of their needs and risks (such as falls or social isolation) to create a dynamic list of patients who will be offered proactive care interventions to improve or sustain their health.

The service has three key aims:

- Benefitting patients with complex needs, and their carers, who are at risk of unwarranted health outcomes by enabling them to stay healthier for longer, with maintained or improved functional ability and enjoy positive experiences of proactive, personalised and self-supported care.
- Reducing need for reactive health care for specific groups of patients and supporting actions to address wider determinants of health.
- Delivering better interconnectedness between all parts of the health system and the voluntary and social care sectors

The aims will be achieved by population segmentation, followed by risk stratification and clinical judgement, to identify people who would benefit most; and multi-disciplinary primary and community teams, including social care and the voluntary sector working together. This will include:

- Maintenance of a comprehensive and dynamic list of identified individuals who would benefit from anticipatory care, based on the outcome of the population segmentation

approach above. The list will be maintained and updated in real time based on population health intelligence.
- The delivery of a comprehensive set of support for those individuals identified as eligible through the anticipatory care list, through an MDT based across PCNs and community service providers.

(iv) Personalised Care

Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual diverse strengths, needs and preferences. This happens within a system that supports people to stay well for longer and makes the most of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences.

The Comprehensive Model for Personalised Care brings together six evidence-based and inter-linked components, each of which is defined by a standard, replicable delivery model. The six key components are:

1. Shared decision making
2. Personalised care and support planning
3. Enabling choice, including legal rights to choose
4. Social prescribing and community-based support
5. Supported self-management
6. Personal health budgets (PHBs) and integrated personal budgets.

(v) Supporting Early Cancer Diagnosis

Through the requirements in the Network Contract DES, primary care networks will:
- Improve referral processes across GP practices, including by introduction of locally agreed standardised systems and processes for identifying people with suspected cancer, referral management and safety netting
- Lead and coordinate the contributions of practices and the PCN to efforts to increase the uptake of existing National Cancer Screening programmes among their local populations
- Improve outcomes through reflective learning and collaboration with local partnerships

Over the four-year period, PCNs should provide a leadership, enablement and support function across their component practices to deliver the service requirements and ensure the highest standards across its practices.
Through the PCN Dashboard, PCNs will have access to a variety of data allowing them to understand and explore trends in cancer presentation and diagnosis locally. National data sets will also enable comparison with other areas and encourage PCNs to learn from one another.
Working with partners, such as Cancer Alliances, local public health commissioning teams and voluntary organisations, offers an opportunity for PCNs to leverage available support, guidance and training.

It is anticipated that the scope of activity undertaken by PCNs will increase year on year, as PCNs become more established and are able to build on what is learnt through audit and exploration of data and significant event analysis in the early years.

1.3 Funding for Network Contract DES

It was noted in the draft Network Contract DES that funding is not allocated directly for delivery of the new specifications, but will instead be through reimbursement for additional workforce roles that will support PCNs deliver the new specifications and alleviate wider workforce pressures. Recruitment decisions by PCNs will depend on local priorities.
The additional roles funding in BNSSG enables the deployment of over 100 additional staff by 2020/21, rising to over 380 by 2023/24 (based on NHS England indicative funding, and average role reimbursement).

1.4 Current Additional Roles Position in PCNs in BNSSG

All PCNs are eligible for reimbursement for additional roles, with the ability from July 2019 to March 2020 to claim 100% reimbursement for 1 Social Prescribing Link Worker per 30,000 (pro rata based on weighted population) and 70% reimbursement for 1 Clinical Pharmacist per 30,000 (pro rata based on weighted population). The table below (table 1) shows the current state of additional roles for Clinical Pharmacists and Social Prescribing Link Workers in BNSSG as of January 2020. The whole time equivalents (WTEs) presented for Clinical Pharmacists includes those who have been transferred across from the NHS England Clinical Pharmacist scheme. The 'Additional Roles Sign-Off Process' was agreed by Primary Care Commissioning Committee on 24th October 2019. Reimbursement from April 2020 will be drawn from allocated PCN funding, with the ability for the PCNs to choose from the additional roles, depending on population requirements.

- The information in table 1 was reported to NHS England for the Additional Roles Reimbursement Scheme return in January 2020
- The information was gathered from PCNs by the Primary Care Contracts Team through Additional Roles claims and a 'ring round' of PCNs.
- The maximum number of potential additional roles for BNSSG PCNs in 2019/20 (based on 1 additional role per 30,000 population for both Social Prescribing Link Workers and Clinical Pharmacists) is 47 across BNSSG. We currently have an additional 25 WTE additional roles in BNSSG and 13.5 WTE Pharmacists transferring to PCNs from the NHS England Clinical Pharmacist Scheme (not included in the 1 role per 30,000 population).
- Prior to the introduction of the Additional Roles Reimbursement Scheme, there were already 45.4 WTE Pharmacists employed by practices in BNSSG and zero Social Prescribing Link Workers employed by practices (NHS England Baseline, March 2019).

Table 1

Additional Roles in BNSSG Jan 2020

	Number recruited by PCNs (whole time equivalents by role)	Number of PCNs that have recruited to additional roles (by role)	Number of PCNs with additional roles out to advert (by role)	Number of PCNs where additional roles staff have been appointed, but awaiting start (by role)	Number of PCNs not yet started to recruit (by role)
Pharmacists	19.4 (13.5 of 19.4 transferred across from NHS England Clinical Pharmacist Scheme)	10	1	1	6
Social Prescribing Link Workers	19	14	1	0	3

1.5 Support from the Wider System

NHSE will be asking CCGs and ICPs to support PCNs and their community providers to institute shared workforce models that can help maximise the collaboration between local partners to deliver the specifications and build the wider PCN. Where PCNs are struggling to recruit to additional role posts, CCGs and system providers should support PCNs through:

- Shared recruitment processes
- Brokering integrated workforce arrangements with other providers eg through rotational posts
- Working with stakeholders to match people to unfilled roles

This will be governed by the Community and Primary Care Workforce Sub Group through to the Local Workforce Action Board (LWAB), and the Primary Care Strategy Delivery Group and STP Integrated Care Steering Group.

1.6 Engagement and Response to NHS England

The CCG has submitted a response to the NHS England consultation, as has Avon LMC and our 18 PCNs. The response was developed both internally within the CCG and following discussions with PCN Clinical Directors on a teleconference on 9th January and a meeting with the LMC on 14th January. The response included support for the ambitions for more joined up and integrated

care for our population and support for the principle of phasing in requirements. The response also voiced concern with regards to the deliverability of the existing proposals given the early stages of development of PCNs and the impact of the proposed workload on practice and PCN resilience. It was particularly noted that new workforce in primary are takes time to establish and train and that this had not been sufficiently factored into the proposed requirements and timescales. The full response has been shared with Clinical Directors and the LMC.

1.7 Support from the CCG

The CCG will support PCNs to strengthen services in readiness for the delivery of the final new PCN specifications. The Locality leadership plans and Sirona, the new community provider in place will support the delivery of the PCN specifications and benefit the wider system. The CCG has already asked clinical and managerial leads within the CCG to map existing initiatives or work streams in place or proposed over the next 2 years which can support delivery of the specifications. This work will be shared with Clinical Directors so that we can develop a collective approach to how the final specifications can support our local system and Long Term Plan.

2. Employment Models for Additional Roles

Employment models have been co-designed with system partners in BNSSG to develop solutions for additional roles in Primary Care which also support system working and the delivery of the network specifications. These will be for PCNs to choose to adopt and we are keen to gage interest from PCNs in adopting these. These solutions offer potential benefits to PCNs and other system providers alike.

2.1 Clinical Pharmacists

Pharmacy leads from across the system, including North Bristol NHS Trust (NBT), University Hospitals Bristol Foundation NHS Trust, Weston Area Health NHS Trust, Avon and Wiltshire Mental Health Partnership NHS Trust, and Community Pharmacy have met with the Medicines Optimisation Team, BNSSG, and designed employment models that will support the system. These are described in appendix 2 (i). Clinical Pharmacists are currently reimbursable in PCNs.

2.2 Social Prescribing Link Workers (SPLW)

There is a working group which includes the area teams, service providers both in health and social care, and Voluntary and 3rd Sector Organisations. The SPLW working group is ensuring plans are put in place to assist with system working, and outcomes are gathered to ensure a consistent offer across BNSSG.

2.3 First Contact Physiotherapists

A Physiotherapy employment model was co-designed with input from the CCG MSK lead, PCN Clinical Directors, Area Team, Sirona and NBT. This model is described in appendix 2 (ii). Unlike other practitioners, Physiotherapists are able to practice in Primary Care Networks without additional skills/training. Physiotherapists will be reimbursable in PCNs from April 2020.

2.4 Paramedics

The Paramedic employment model has been designed with input from South Western Ambulance Service NHS Foundation Trust (SWASFT) and the Training Hub and is described in appendix 2 (iii). This has yet to be shared across the wider system, but is an example of how additional Paramedics in Primary Care can support wider system working. Paramedics will not be reimbursable in PCNs until April 2021.

2.5 Physicians Associates (PAs)

An employment model is currently being drafted. PAs receive their clinical supervision from Medical Practitioners; the employment model does not need to include robust clinical supervision from other partners in the BNSSG system. Also of note is that there are small numbers of PAs currently working in BNSSG, therefore it is unlikely that their introduction into PCNs in April 2020 will impact on other areas of the system.

3. PCN Organisational Development Funds

3.1 Background

BNSSG has been awarded £718K for the development of PCNs, to include both organisational development and leadership development. The development of PCNs is based on the self-assessed maturity matrix (appendix 3), with a majority of PCNs in BNSSG having assessed themselves at 'foundation step'.

The national view is that PCNs need to be at 'step 3' by 2021.It was noted that there is little time to achieve 'step 3' and we therefore need to build a programme with PCN CDs that is relevant and realistic.

We have requested permission from PCNs to share their Maturity Matrices with all BNSSG PCNs and we will ask those PCNs who have self-assessed at a higher level to present at a future CD and Locality Leads meeting.

An initial PCN OD and Leadership Development steering group meeting, held by teleconference, took place on 21st November 2019. The group included PCN Clinical Directors, PCN Management Leads, Area Team, the Training Hub and the Primary Care Development Team.

It was acknowledged that a proportion of the PCN development funds need to be invested in Clinical Directors, however we also need to invest in supporting the PCN teams.

Five PCNs have been invited to participate in the Population Health Management (PHM) Wave 2 programme starting from 27th February. The PCNs embarking on the programme will be developed through the maturity matrix in the 'Use of Data and Population Health Management' domain and all PCNs will be invited to participate in a learning event as part of the programme.

3.2 Work to Date

An initial meeting was held with the Clinical Directors and Locality Leads on 2nd October 2019. This was in the format of a workshop, with a table set out for each domain of the self-assessment maturity matrix (appendix 3). The attendees visited each facilitated table and discussed what they needed in their PCN to be able to progress through the maturity matrix. It was agreed at this workshop that there would be an OD/Leadership Steering Group on 21st November 2019, to take forward a clear plan of leadership and organisational development. A request was made for

Clinical Directors (CD) and PCN Manager Leads to sign up to be part of the steering group, with at least one CD from each locality, with a reminder sent out in the PCN Bulletin Number 5.
The outputs of the 1st OD/Leadership Steering Group meeting included:

- Needs identified to date from the range of self-assessment Maturity Matrices across BNSSG (appendix 2)
- We agreed that this meeting was a 'sub-set of PCNs' and we will continue to engage with the wider PCN network in BNSSG to ensure all views are captured
- Next steps including timeline of specifications, which will include a data workshop for PCNs
- Developing a directory of providers of PCN OD/Leadership Development identified to date and how these map to the maturity matrix, and free offers were highlighted to PCNs e.g. South West Leadership Academy 'Developing Leadership in Primary Care'; NHS England 'Time for Care Programme'.

A paper regarding Organisational Development and Leadership funds was discussed at Executive Team on 18th December 2019.
The following information was requested:

- To look into the possibility of funding CDs to attend the Peloton Programme with other BNSSG system leaders; a leadership programme co-designed by BNSSG STP
- Describe 'what good looks like'

A verbal summary of the outline of the approach was shared on a teleconference with Clinical Directors on 9th January 2020 with a commitment to sharing more at the PCN CDs and locality leads meeting on 22nd January 2020 before proposals are presented to the Primary Care Commissioning Committee on 28th January 2020 for support.

3.3 Key Points/Principles

Clinical Directors and Network Managers at the PCN OD/Leadership Steering Group are keen to have a process in place for accessing the PCN development funds.

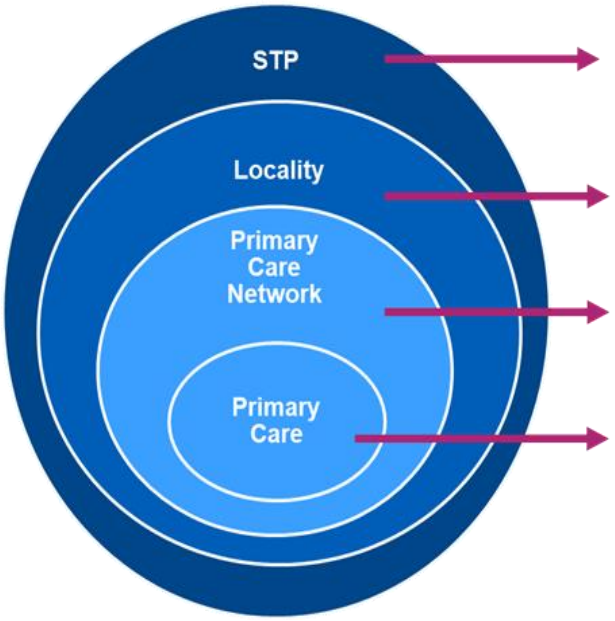
'What Good Looks Like'

Primary Care Network Organisational Development needs to align with BNSSG as a system.

The development of PCNs is fundamental to achieving our system goals and delivering integrated care for our population. This is clearly set out in our BNSSG Primary Care Strategy with its stated aim:

"A resilient and thriving Primary Care at the heart of an Integrated Health and Social Care system by 2024'".

This is visually represented in the diagram below:



Long term plan	Function
Integrated Care System (ICS) **(System)**	Strategic Governance Vision Overall Accountability
Integrated Care Partnerships (ICP) Provider Alliance **(Place)**	Planning and coordination across providers
Primary Care Networks **(Neighbourhood)**	Practices working together Resilience Local Delivery Shared Resource
General Practice IUC Community Pharmacy Dental Optometry	Personalised Community Based 24/7 Care

Supporting PCNs to develop will both support greater resilience in general practice and underpin and enable the delivery of integrated care at locality level. PCNs submitting proposals for OD and leadership funding will therefore be asked to demonstrate how their proposals support and align with developing this system of care.

Key components of good organisational development support would be expected to include highly practical and specific help on:

- Building flourishing teams
- Multi-disciplinary team (MDT) development focused on joint work across practices and with community partners
- Team development
- Developing good, healthy and positive environments in which to work
- Building environments and creating cultures which are driven by continuous development and support
- Setting up to succeed
- Development of system-wide learning culture
- Enabling and encouraging sharing of good practice
- Encouraging progression through organisational and personal growth
- Enabling a culture of continuous improvement
- Working collaboratively
- Developing trusted relationships with STPs, ICSs and the wider community
- Developing trusted relationships with local people and their communities

The prospectus details the requirements of PCNs and the benefits.
The OD and Leadership Development funds will ensure that PCNs:

- Understand their own journey: know where they are aiming to get to over the next five years, use a diagnostic process to establish development need, using a maturity matrix or similar tool, and put a development plan in place
- Be functioning increasingly well as a single team
- Be part of a 'network of PCNs' that helps shape the STP/ICS plan to implement the Long Term Plan
- Form clear and agreed multi-disciplinary teams with community provider partners
- Build on existing relationships, form links with local people and communities to understand how to work most effectively for their benefit
- Have made 100% use of their funding entitlement for additional roles in line with national guidance
- Have started work on service improvement projects, linked to Long Term Plan goals
- Have started thinking about their future estate needs, jointly with community partners
- Be ready to deliver new national service specifications from April 2020

In discussion with Clinical Directors some examples of good practice either undertaken or proposed have already been highlighted to us:

- Facilitated vision workshops for the PCN to develop a shared sense of purpose and vision
- Whole staff PCN events for the practice staff within a PCN to raise awareness and understanding of what being part of a network means
- Pilot new workforce models working with community and VCSE partners at scale
- Developing governance and leadership across the PCN with agreed clinical, managerial and analytical leadership roles across a PCN
- Facilitated workshops to explore the roles and leadership arrangements between localities and PCNs

The Primary Care Development Team is committed to continuing to share examples of good practice across the PCNs through the PCN and Locality Leads forum.

As a result, the following proposals are recommended:

Proposed spend of £718,000 in 2019/20

1. **£638,000**
   It is proposed that each PCN will be given a share of £638,000 based on PCN size (62p per patient, based on an unweighted population of 1,026,000 in BNSSG).

   The rationale to support reflecting population size is that the larger PCNs have a greater number of practices to work with to progress through the maturity matrix, a greater number of partners, community teams and Voluntary and 3rd Sector Organisations which will involve more complexity, effort and time to support.

   To access these funds, the PCN or Locality will have to:

- Submit a business case to BNSSG CCG by 31st March 2019 to ensure the funds are committed in 2019/20. A template will be developed to support this.
- Show progression against the maturity matrix as a result of the funds
- Show a commitment to working with the CCG and system in delivering the new specifications and our locally agreed pathways in 2020
- Demonstrate how they will address a number of the "What Good Looks Like" requirements within the Key Principles section
- Show how the plans align to the BNSSG system and support localities to develop Integrated Care Partnerships

Principles for Business Cases

- It must show progression through at least one of the five maturity matrix domains:
  - Leadership, Planning and Partnerships
  - Use of Population Health Management
  - Integrating Care
  - Managing Resources
  - Working with People and Communities
- The funding must not fund services already funded in Primary Care
- The business case can be submitted as a PCN or as a Locality. It is expected that a proportion of the funds will be used to support individual PCN development and a proportion to support locality development. PCNs will be required to demonstrate locality support for their proposals and Area Teams will be able to support PCNs in developing these.

The business cases will be considered and signed off by a team comprising:

- Medical Director of Primary Care
- Area Director
- Head of Locality Development
- Head of Primary Care Development
- Head of Primary Care Contracts

A panel meeting to review proposals will be convened for the week beginning 20th April with outcomes provided to PCNs by 1st May.

N.B. PCNs that wish to progress their applications more quickly will have their applications reviewed virtually with a commitment to a response within 2 weeks of receipt of their application from 1st February onwards.

2. **£80,000**
   "Supporting the development of PCN Clinical Directors so that they can create thriving PCNs is a significant priority. Considerable funding (£3,000-4,000 per CD) has been allocated to systems for this purpose so that they can ensure there is a comprehensive offer available for all", PCN Development Support –Guidance and Prospectus 09/08/2019.

A 6 day leadership course (Peloton Programme) has been co-designed by BNSSG STP for BNSSG system leaders. It is proposed that this course is offered to PCN Clinical Directors (CDs) and participation is funded using PCN OD/Development funds. The total cost of the programme for 20 CDs (2 PCNs have job shares) is £30K (£1500 per CD). The CDs would join the course with other leaders from BNSSG partner organisations. The next cohort of the Peloton Programme is due to run in the summer of 2020. PCN Clinical Directors would need to submit an Expression of Interest to attend the programme. Assurances would be sought about Return on Investment from these leaders – including commitment to continuing in the role and how the learning from the course would be spread and disseminated within the wider PCN leadership board/team.

The objectives of the Peloton systems leadership programme are to:

- Build strong relationships beyond organisation boundaries
- Agree and progress system goals, whilst balancing alignment to organisation objectives
- Support cultural change, moving from competition to cooperation and from organisation first, to system first
- Translate this approach for colleagues within your individual organisations
- Develop insight into leading transformational change – at the individual, organisational and system level
- Develop a community of influential change agents for the wider BNSSG system

The intended outcomes from participating in Clinical Director leadership development are:

- Enhanced personal development,
- Development of skills and techniques to lead a PCN
- Developing our leadership within an Integrated Care System

The remaining 50k would be available for PCN leaders to submit proposals for personal leadership development or coaching tailored to their own needs. This is to recognise the need for ongoing leadership development and to acknowledge that PCN leaders will have varied levels of experience and therefore a flexible offer will support them to identify their own development needs. An expression of interest process will be developed to support this. This could also extend to other members of the PCN leadership team.

The Primary Care Commissioning Committee meeting of January 28th is asked to agree key proposals regarding the allocation of the PCN development funds in BNSSG:

- PCNs/Localities will be asked to submit proposals for their share of £638K of PCN OD/Leadership Development funds which will be shared on an unweighted population size (to the value of 62p per patient). These will need to set out how they will address the requirements described in this paper
- The remaining £80K will be used to deliver the 6 day Peloton Leadership Programme for Clinical Directors from the Primary Care Networks in BNSSG (£30K), with the remainder of funds (£50K) available for individuals working in PCNs to apply for leadership development

BNSSG CCG has not yet been officially notified of recurrent funds for PCN Development past 2019/20. If the funds are recurring, it is proposed that the funds will be used to implement further waves of population health management, developing a programme within BNSSG (currently only 5 PCNs can sign up to the NHSE PHM scheme); that there is further development of the integration of care across the BNSSG wide system; and there is investment in progressing MDT opportunities through the new additional roles in PCNs, investment in wider leadership development opportunities for PCN board members (clinical and non-clinical) and in clinical leadership development in support of the new specifications.

As part of evaluating this approach we will ask PCNs to provide a brief report on the benefits of their Leadership and OD with a commitment to sharing this with other PCNs and we will work with PCN Clinical Directors to reassess maturity on the maturity matrix in the autumn of 2020 in order to inform our approach for next year.

4. Financial resource implications

4.1 Locally Enhanced Service and Duplication in Draft PCN Specifications

Following the publication of the final version of the PCN Specifications in February 2020, the Locally Enhanced Service (LES) agreements in BNSSG will be reviewed. There are areas of duplication present in the draft specifications.
The delivery of all of the new PCN specifications will be dependent upon timely recruitment into the new PCN additional roles posts. Section 1.3 above shows that PCNs have not yet recruited to their full quotas of additional roles posts, and the CCG will continue to support PCNs with recruitment and models of employment.
The draft Outline Service Specifications guidance requires that CCGs work with PCNs, community providers and Local Medical Committees to support transition to the new specifications and further requirements in relation to local CCG investment and the transition to the national specification is expected to be set out at the conclusion of the GP contract negotiations for 2020/2021.

4.2 PCN Leadership and Organisational Development

PCN Leadership and Organisational Development will have no financial implications for BNSSG CCG as NHS England has funded the STP £718K. These funds are currently being held by BNSSG CCG pending approval of these proposals by the Primary Care Commissioning Committee.
Additional roles are reimbursed by NHS England and will be accessed by each PCN from the funds based on weighted population from NHS England and held with BNSSG CCG.

5. Legal implications

The CCG will follow its procurement policies as appropriate in the mobilisation of the organisational development and leadership development plans for Primary Care Networks.

6. Risk implications

RISK	MITIGATION

There is a risk that if the funds are given directly to PCNs without any guidance the PCNs may not progress through the maturity matrix	Clear guidance is needed for PCNs regarding the process for applying for funds, and clear mapping on the maturity matrix with input from area team to show progression
If funding is given to the PCNs that have progressed further there is a risk that those PCNs that are at the earlier stage of the maturity matrix will be 'left behind'	Consideration needs to be given regarding where PCNs are in the maturity matrix when agreeing the principles for accessing the PCN development funds
There is a risk that PCNs have assessed themselves inaccurately on the maturity matrix and are further ahead or behind the point at which they have self-assessed	Area teams will work with PCNs to ensure they are mapping appropriately across the system
There is a risk that there are interdependencies with the current Care Home LES that could be in conflict with the new Enhanced Health in Care Homes specification	A full table top review of Locally Enhanced Services should be carried out once the final version of the Network DES has been released
If PCNs have not recruited to their maximum additional roles capacity, then there may not be enough additional roles in place currently to deliver the requirements of the network DES	The CCG will work with the PCNs to ensure they are aware of their additional roles budget, and will assist with the development of employment models and recruitment drives to ensure PCNs have the staff to deliver the network DES

7. How does this reduce health inequalities

PCNs are being supported in collaboration with Area Teams to ensure they deliver at locality level and PCN level depending on the population requirements of PCNs and localities to reduce health inequalities in BNSSG. The locally agreed action to tackle inequalities specification will come into effect from 2021.

8. How does this impact on Equality and Diversity?

There have been no implications for equality and diversity identified.

9. Consultation and Communication including Public Involvement

We are engaging with patients and the public as well as with professionals in the refresh of the Primary Care Strategy and as part of this we have asked about the opportunities for Primary Care Networks in BNSSG and this will inform our development plan. The key messages have been about the opportunity for sharing and spreading resources and good practice across a wider population.

We held a workshop with Clinical Directors in October to shape the needs for an OD programme and we have held a teleconference with Clinical Directors to respond to the NHSE consultation for the draft new PCN specifications.

10. Next Steps

- A letter has been sent to PCN CD's reminding them of their additional roles allocation for 2019/2020, setting out allocations for 2020/2021 and the process for claiming reimbursement
- Await publication of final version of network specifications following consultation
- Next BNSSG CCG GP Locality Representatives and PCN Clinical Directors Meeting on 22nd January 2020 to update PCNs on PCN Development, Specifications, Improved Access and Workforce
- Primary Care Commissioning Committee Workforce Seminar on 25th February 2020 to discuss additional roles, employment models and delivery of the new specifications
- Prepare for delivery of specifications:
    - BNSSG CCG will plan how they will help to co-ordinate and support the delivery of the new specifications, including supporting PCNs with recruitment
    - Area teams to work closely with PCNs to ensure additional workforce is optimal to deliver new specifications
    - BNSSG CCG will work with PCNs and Community provider to enable shared workforce models
    - Ensure the reimbursement process within BNSSG CCG supports new employment models
    - Review current LES arrangements with regards to the new specifications
    - PHM packs will be available for each PCN from January 2020 and 5 PCNs have been invited to participate in the NHSE Wave 2 intensive PHM pilot starting from 27th February 2020

11. Recommendations

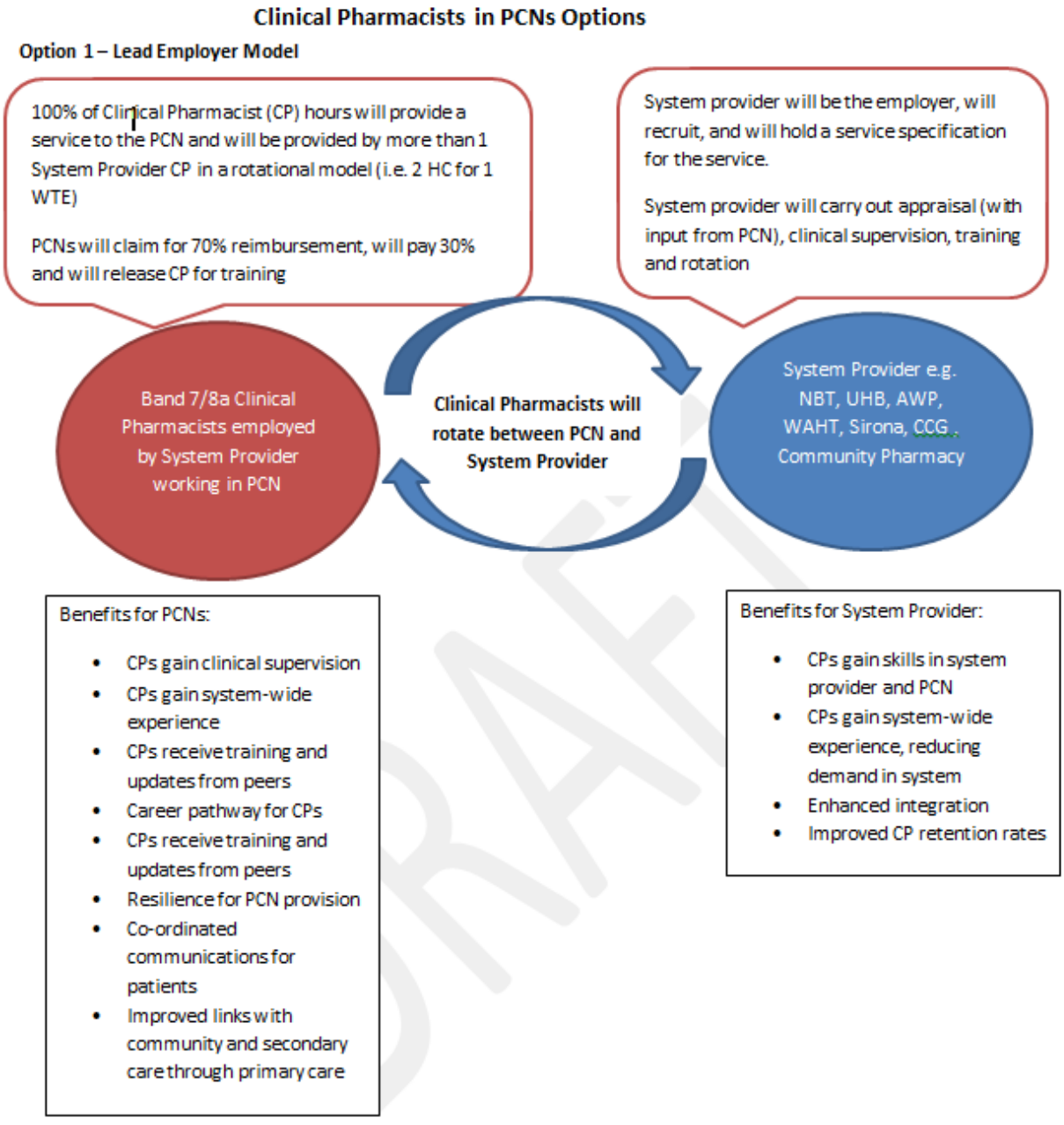
- PCCC are asked to approve the proposals for supporting PCN Leadership and Organisational Development
- PCCC are invited to discuss the local implications arising from this paper and to review next steps

12. Appendices

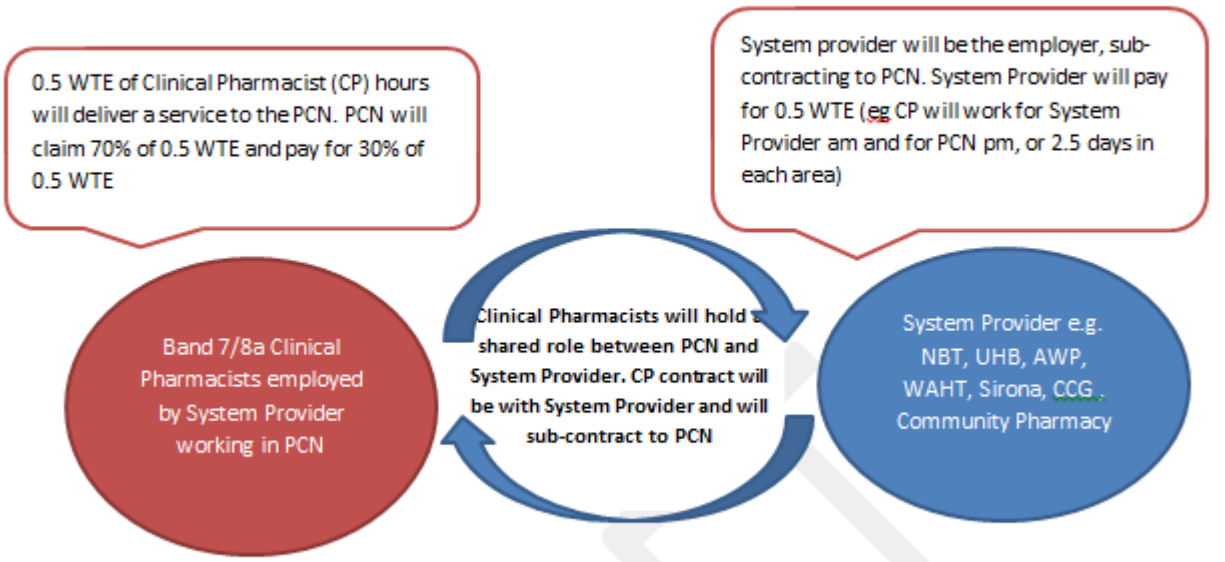
Appendix 1

Employment Models for Additional Roles

(i) Clinical Pharmacists



Option 2 – Rotational/ Joint (One Employer)



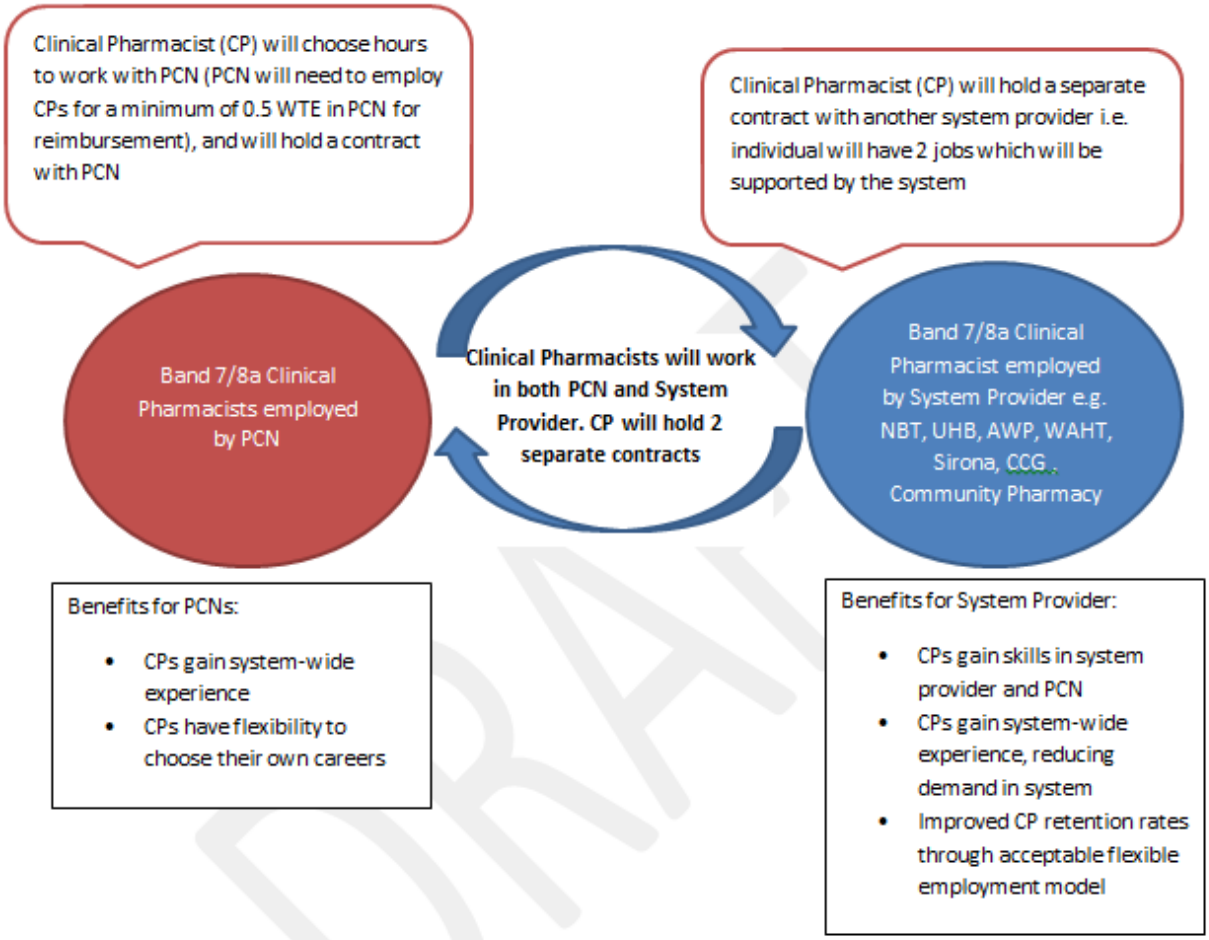
Benefits for PCNs:

- CPs gain system-wide experience
- CPs receive training and updates from peers
- Resilience for PCN provision
- Co-ordinated communications for patients
- Improved links with community and secondary care through primary care

Benefits for System Provider:

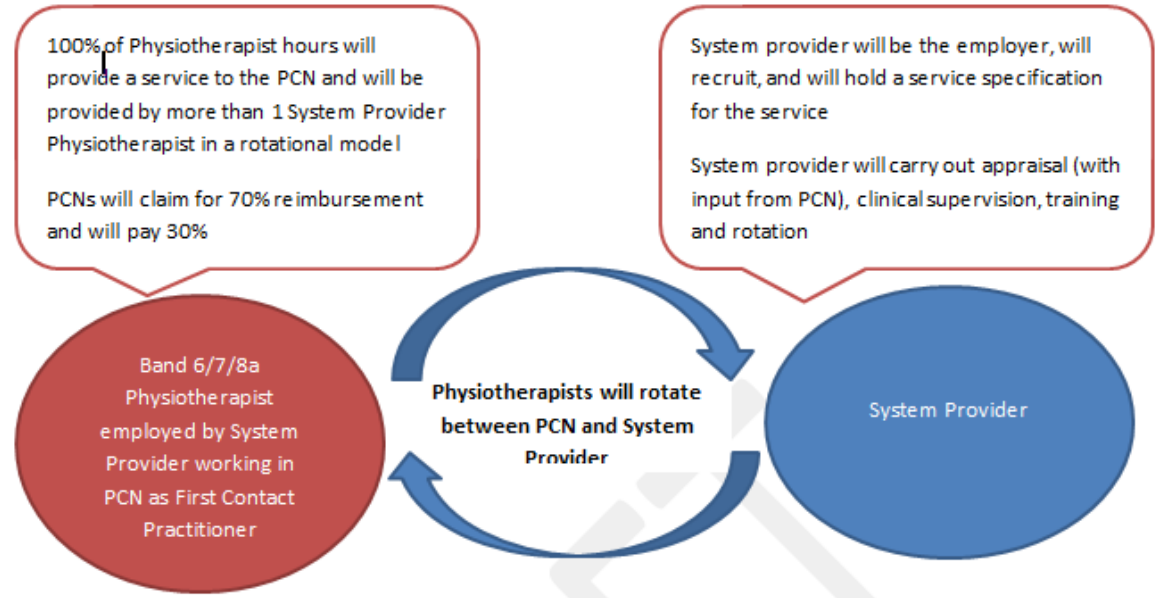
- CPs gain skills in system provider and PCN
- CPs gain system-wide experience, reducing demand in system
- Enhanced integration
- Improved CP retention rates through attractive job offer

Option 3 – Portfolio Model for Clinical Pharmacists – includes rotational and joint posts but separate employers



(ii) First Contact Physiotherapists

First Contact Physiotherapists in PCNs Proposal



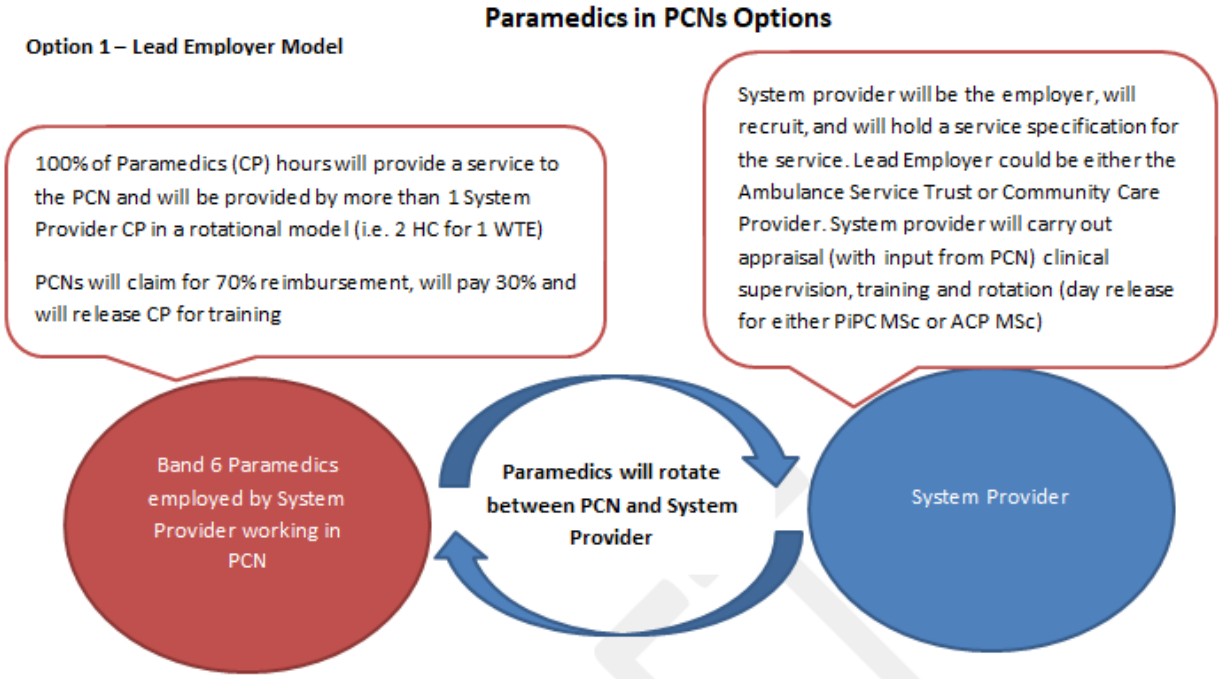
Benefits for PCNs:

- Physiotherapists gain clinical supervision
- Career pathway for Physiotherapists
- Physiotherapists gain system-wide experience
- Physiotherapists receive training and updates from peers
- Resilience for PCN provision
- Co-ordinated communications for patients
- Improved links with community and secondary care through primary care

Benefits for System Provider:

- Physiotherapists gain skills in system provider and PCN
- Physiotherapists gain system-wide experience, reducing demand in system
- Enhanced integration
- Improved Physiotherapist retention rates
- Links with agreed MSK pathway

(iii) Paramedics



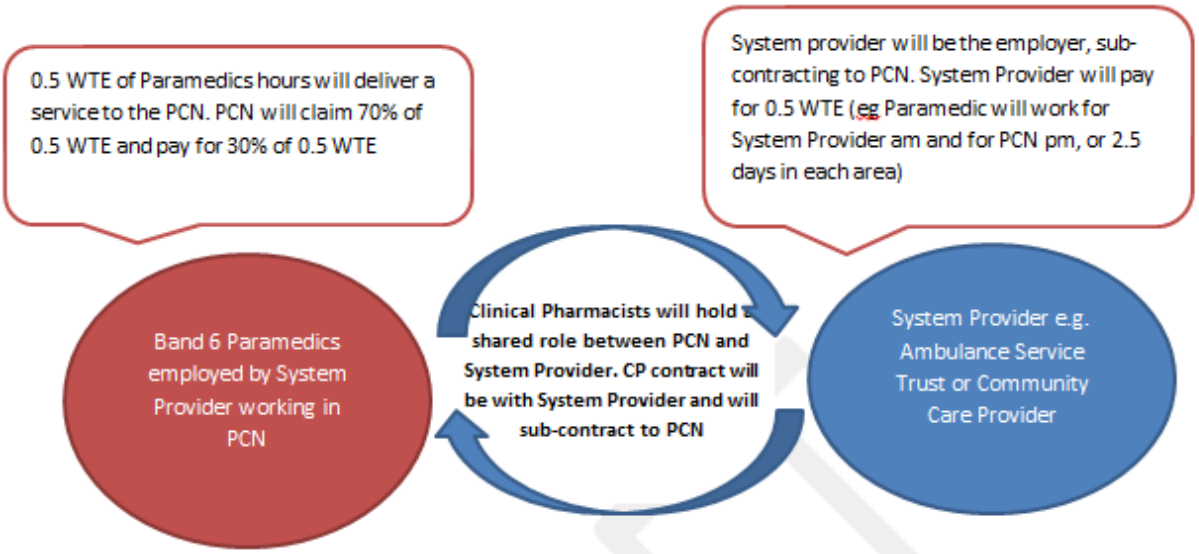
Benefits for PCNs:

- Paramedics gain system-wide experience
- System employer provides indemnity
- Career pathway for Paramedics
- Resilience for PCN provision
- Improves Paramedics skills around treat, refer discharge of patients when working with system provider
- Improved links with community and secondary care through primary care
- Paramedics being specialist generalist align well to existing PCN consultation models
- Opportunity to develop Paramedics via PiPC or ACP MSc (Self-Funding or via Apprenticeship supported by levy paying System Provider) No Levy transfer required

Benefits for System Provider:

- Paramedics gain skills in system provider and PCN
- Paramedics gain system-wide experience, reducing demand in system
- Enhanced integration
- Improved Paramedic retention rates
- Paramedics gain clinical supervision within General Practice
- Paramedics receive training and updates from PCN providers
- Option to recruit into Newly Qualified Paramedics directly from University rather than moving within system; would need to be supported by a recognised post graduate education pathway such as HEE Paramedic in Primary Care (Self-funded by student) or ACP MSc (Apprenticeship)

Option 2 – Rotational Post Model



Benefits for PCNs:

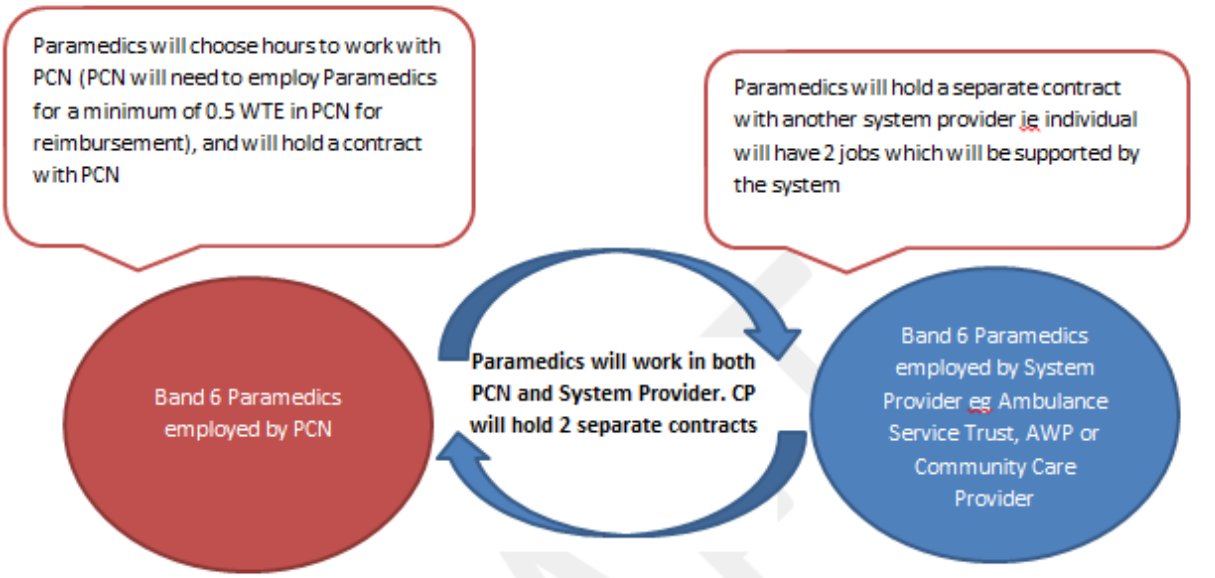
- Paramedics gain system-wide experience
- System employer provide indemnity
- Resilience for PCN provision
- Improves Paramedics skills around treat, refer discharge of patients when working with system provider
- Improved links with community care through primary care
- Improves Paramedics skills around treat, refer discharge of patients when working with system provider
- Opportunity to develop Paramedics via PiPC or ACP MSc (Self-Funding or via Apprenticeship supported by levy paying System Provider) No levy transfer required

Benefits for System Provider:

- CPs gain skills in system provider and PCN
- CPs gain system-wide experience, reducing demand in system
- Paramedics gain clinical supervision within General Practice
- Enhanced integration
- Improved CP retention rates through attractive job offer
- Option to recruit into Newly Qualified Paramedics directly from University rather than moving within system; would need to be supported by a recognised post graduate education pathway such as HEE Paramedic in Primary Care (Self-funded by student) or ACP MSc (Apprenticeship)

Draft Paramedic Proposal 2/12/19

Option 3 – Portfolio Model for Paramedics



Benefits for PCNs:

- Paramedics gain system-wide experience
- Paramedics have flexibility to choose their own careers
- Improves Paramedics skills around treat, refer discharge of patients when working with system provider
- Improves Paramedics skills around treat, refer discharge of patients when working with system provider

Benefits for System Provider:

- CPs gain skills in system provider and PCN
- CPs gain system-wide experience, reducing demand in system
- Paramedics gain cross sector clinical supervision
- Improved CP retention rates through acceptable flexible employment model
- Option to recruit into Newly Qualified Paramedics directly from University rather than moving within system; would need to be supported by a recognised post graduate education pathway such as HEE Paramedic in Primary Care (Self-funded by student) or ACP MSc (Apprenticeship)

Draft Paramedic Proposal 2/12/19

Appendix 2
Maturity Matrix

BNSSG PCN Maturity Matrix Returns October 2019 X=BNSSG PCN						
		Pre-foundation	**Foundation**	**Step 1**	**Step 2**	**Step 3**
Leadership, Planning and Partnerships	**For the PCN**	X X X	X X X X X X X X X X X	X X X	X	
	For Systems	X X X X X X X	X X X X X X X X	X X	X	
Use of Data and Population Health Management	**For the PCN**	X X X X X X X	X X X X X X X X	X X		X
	For Systems	X X X X X X X X X X	X X X X X X X			X
Integrating Care	**For the PCN**	X X X X	X X X X X X X	X X X X		

			X X X			
	For Systems	X X X X X X X X	X X X X X X X X X	X		
		Pre-foundation	**Foundation**	**Step 1**	**Step 2**	**Step 3**
Managing Resources	**For the PCN**	X X	X X X X X X X X X X X X X	X	X X	
	For Systems	X X X X X X	X X X X X X X X X X X	X		
Working with People and Communities	**For the PCN**	X X X X X X X	X X X X X X X X	X X	X	
	For Systems	X X X X X	X X X X X		X	

		X X X X X X	X			

Appendix 3
Maturity Matrix Diagnostic Tool

13. Glossary of terms and abbreviations

PCNs	Primary Care Networks are groups of GP practices working collaboratively in a formalised structure, typically covering a population of 30,000 to 100,000 patients, and combining with other primary and community services and local organisations to ensure an integrated approach to health and care for that population.
CDs	Clinical Directors are in place in each PCN and are the clinical leads for PCNs with overall responsibility for the functioning of the PCN.
OD	Organisational development is the term to explain how PCNs will grow or progress into the network required to deliver future services.
ICP	Integrated Care Partnership. In an integrated care system, NHS organisations, in partnership with local authorities and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.
DES	Direct Enhanced Services. Enhanced services are, in essence, elements of essential or additional services delivered to a higher specification, or medical services outside the normal scope of primary medical services, which are designed around the needs of the local population.
LES	Locally enhanced services are schemes that are agreed locally between clinical commissioning groups and primary care service providers to meet locally identified needs and priorities.
LMC	The Local Medical Committee (LMC) is an independent, self-financing body, with statutory functions, which is formally recognised by the Secretary of State for Health.

SMR	Structured Medication Review. A structured medication review is a way to simplify and optimise complicated medication schedules with the aim of improving patients' quality of life, and reducing unplanned and avoidable hospital admissions.
MDT	Multi-disciplinary team is a team of different professionals from health and social care which works together for the benefit of the patient, improving treatment pathways and communication.
PHB	A personal health budget is an amount of money to support someone's health and wellbeing needs, which is planned and agreed between the individual or their representative, and the local clinical commissioning group (CCG). It isn't new money, but a different way of spending health funding to meet the needs of an individual. Personal health budgets are a way of personalising care, based around what matters to people and their individual strengths and needs. They give people with long term health conditions and disabilities more choice, control and flexibility over their healthcare.
PHM	Population Health Management is an emerging technique for local health and care partnerships to use data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources.
MSK Physiotherapist	Musculoskeletal Physiotherapist is a Physiotherapist specially trained to treat people with musculoskeletal conditions, including conditions that affect joints, bones, bones, muscles and back pain.

PCN MATURITY MATRIX DIAGNOSTIC TOOL

This matrix has been created to help primary care networks and other local organisations involved in the development of PCNs to self-assess the current maturity of a network and to help understand the development trajectory of the network. The matrix is provided here in the format of a simple spreadsheet tool, that is intended to be used flexibly and in a way that most effectively supports local PCN development.

It is recommended the matrix will have most value when completed as part of a facilitative discussion, involving the providers who will be delivering services within the network now and in the future, and with their commissioners. It is for local agreement whether the matrix is completed by a single network or a number of networks undertake a review collaborating together across a place or CCG footprint. What is more important is that the outputs from the discussion can meaningfully inform the on-going development of the network(s) involved, and the development needs for each network is understood.

Components of the matrix

The matrix is divided into **five development themes** (by row):
1. Leadership, planning and partnerships
2. Use of data and population health management
3. Integrating care
4. Managing resources
5. Working with people and communities

For each development theme there are then up to **four development steps** - Foundation, Step 1, Step 2 and Step 3 (by column).

Within each theme and step there are a number of **maturity components** (the cells). There are a number of blank cells in the matrix and this is intentional.

The development of PCNs is a partnership between the organisations within the network, supported by and working with other local health and care organisations. Therefore for each theme and development step, the matrix differentiates between maturity components that align with individual PCNs and those components that align with systems supporting PCNs. This is denoted in the spreadsheet as components 'For the PCN' and 'For Systems'. It is for local determination whether the matrix is only completed for the network components or for both network and system components, subject to the approach that will best inform discussions on the developments and transformation changes that are already in place, are underway or are required. For example, it may be agreed locally that each network undertakes its own review for the PCN maturity components, and then representatives from networks (e.g. PCN Clinical Directors) come together as a group with wider system and place organisations for a shared strategic review of current maturity of the system components.

To complete the tool
1. Agree locally who will complete the matrix and the nature of the discussion that will be held to build an overall view across the network, and whether this will include the system components. There is space on the matrix worksheet to record the name of the network and the date if this is useful locally.

2. For each maturity component, by theme and development step, assess whether the network (and system where applicable) already has the component in place and record with an X in columns D, F, H and J. The matrix worksheet it not protected and this provides the option for networks to additionally record in free text whether any components are 'in place', 'in plan' or 'in progress' - if that is the preferred local approach. In this case, an X would denote that a component is already in place.

3. Review the overall aggregate position across the themes for all development steps where components are **in place** and note in column K. It is normal if a network concludes that some development themes are overall (for example) at Foundation and others at Step 1. This should help identify areas for further focus and there is a final column L for capturing any free text comments that arise in reviewing the aggregate position.

4. Having completed the diagnostic, this should help inform discussions on where the network would like to prioritise its development, using the PCN Development Prospectus as a guide to framing this further and identifying specific support activities. This information could also be captured in summary in

Primary Care Network Maturity Matrix

Network	*Insert name of network*										*Date*
Themes	**PCN/Systems**	**Foundation**	**X**	**Step 1**	**X**	**Step 2**	**X**	**Step 3**	**X**	**Overall position**	**Comments**
Leadership, planning and partnerships	For the PCN	The PCN can articulate a clear vision for the network and actions for getting there. GPs, local primary care leaders, local people and community organisations, the voluntary sector and other stakeholders are engaged to help shape this.		The organisations within the PCN have agreed shared development actions and priorities.		The PCN has established an approach to strategic and operational decision-making that is inclusive of providers operating within the network footprint and delivering network-level services. There are local governance arrangements in place within networks to support integrated partnership working.		PCN leaders are fully participating in the decision making at the system and relevant place levels of the ICS/STP. They feel confident and have access to the data they require to make informed decisions.			
		Clinical directors are able to access leadership development support.		Joint planning is underway to improve integration with broader 'out of hospital' services as networks mature. There are developing arrangements for PCNs to collaborate for services delivered optimally above the 50k footprint.		The PCN Clinical Director is working with the ICS/STP leadership to share learning and support other PCNs to develop.					
				There are local arrangements in place for the PCN (for example through the PCN Clinical Directors) to be involved in place/system strategic decision-making that both supports collaboration across networks and with wider providers including NHS Trusts/FTs and local authorities.							
	For Systems	Systems are actively supporting GP practices and wider providers to start establishing networks and integrated neighbourhood ways of working and have identified resources (people and funding) to support PCNs on their development journey.		Primary care is enabled to have a seat at the table for system and place strategic planning.		Primary care is enabled to play an active role in strategic and operational decision-making, for example on Urgent and Emergency Care. Mechanisms in place to ensure effective representation of all PCNs at the system level.		Primary care leaders are decision making members of the ICS and place level leadership, working in tandem with partner health and care organisations to allocate resources and deliver care.			
		Systems have identified local approaches and teams to support PCN Clinical Directors with the establishment and development of networks and for clinical directors in their new roles.		As set out in the LTP, there is a system level strategy for PCN development and transformation funding, with support made available for PCN development. System leaders supports PCN clinical directors to share learning and support development across networks.		PCN Clinical Directors work with the ICS/STP leadership to share learning and work collaboratively to support other PCNs.					
Use of data and population health management	For the PCN	The PCN is using existing readily available data to understand and address population needs, and are identifying the improvements required for better population health.		Analysis on variation in outcomes and resource use between practices and PCNs is readily available and acted upon.		All primary care clinicians can access information to guide decision making, including identifying at risk patients for proactive interventions, IT-enabled access to shared protocols, and real-time information on patient interactions with the system.		Systematic population health analysis allows the PCN to understand in depth their population's needs, including the wider determinants of health, and design interventions to meet them, acting as early as possible to keep people well and address health inequalities. The PCN's population health model is fully functioning for all patient cohorts.			
				Basic population segmentation is in place, with understanding of key groups, their needs and their resource use. This should enable networks to introduce targeted interventions, which may be initially focussed on priority population cohorts		Functioning interoperability within networks, including read/write access to records.		Ongoing systematic analysis and use of data in care design, case management and direct care interactions support proactive and personalised care			
				Data and soft intelligence from multiple sources (including and wider than primary care) is being used to identify interventions.							

	For Systems	Infrastructure is being developed for PHM in PCNs including facilitating access to data that can be used easily, developing information governance arrangements & providing analytical support.		Basic data sharing, common population definitions, and information governance arrangements have been established that supports PCNs with implementation of PHM approaches.		There is a data and digital infrastructure in place to enable a level of interoperability within and across PCNs and other system partners, including wider availability of shared care records		Full interoperability is in place across the organisations within PCNs, including shared care records across providers.				
				There is some linking of data flows between primary care, community services and secondary care.		Analytical support, real time patient data and PHM tools are made available for PCNs to help understand high and rising risk patients and population cohorts, and to support care design activities.		System partners work with PCNs to design proactive care models and anticipatory interventions based on evidence to target priority patient groups and to reduce health inequalities.				
Integrating care	For the PCN	The PCN is starting to build local plans for improving the integration of care for their populations, informed by the Long Term Plan, GP contract framework and locally agreed system/place priorities.		Integrated teams, which may include social care, are working within the network and supporting delivery of integrated care to the local population. Plans are in place to develop MDT ways of working, including integrated rapid response community teams and the delivery of personalised care.		Early elements of new models of care defined at Step 1 now in place for most population segments, with integrated teams including social care, mental health, the voluntary sector and ready access to secondary care expertise. Routine peer review takes place.		Fully integrated teams are in place within the PCN, comprising of the appropriate clinical and non-clinical skill mix. MDT working is high functioning and supported by technology. The MDT holds a single view of the patient. Care plans and co-ordination in place for all high risk patients.				
		The PCN is aware of the organisations they need to engage to develop multi-agency approaches to integrated care and are beginning to make initial approaches.		Components of comprehensive models of care are defined for all population groups, with clear gap analysis and workforce plans.		The PCN and other providers have in place supportive HR arrangements (e.g. formalised integrated team governance and operational management) that enable multi-agency MDTs to work together effectively.		There are fully interoperable IT, workforce and estates across the PCN, with sharing between networks as needed.				
	For Systems	Systems support the PCNs to build relationships across physical and mental health service providers and social care partners to facilitate the delivery of Integrated care.		Systems support the building of relationships across providers of physical and mental health services, and social care partners.		There is continued development of partnerships across primary care, community services, social care, mental health, the voluntary sector and secondary care that are enabling on-going MDT development. Workforce sharing protocols in place.		Systems have developed and implemented integrated care models that meet with objectives of the LTP.				
				System workforce plans supports the development of integrated neighbourhood teams.								
Managing resources	For the PCN	Primary care, in particular general practice, has the headroom to make change		Steps taken to ensure operational efficiency of primary care delivery, such as delivering the Time to Care programme, and support general practices experiencing challenges in delivery of core services.		The PCN has sight of resource use and impact on system performance and can pilot new incentive schemes where agreed locally.		The PCN takes collective responsibility for managing the resource flowing to the network. Data is used in clinical and non-clinical interactions to make best use of resources.				
		There are people available with the right skills to make change happen.										
	For Systems	System plan in place to support managing collective financial resources that includes PCNs.		Systems have put in place arrangements that support PCNs with improvements in the efficiency of primary care delivery and enable PCNs to make optimum use of their resources.		Systems support networks to have sight of resource use and impact on system performance and that can enable piloting of new incentive schemes.		Systems support PCNs to take collective responsibility for managing the resource flowing to the network and use data in clinical and non-clinical interactions to make best use of resources.				
		PCN development support funding is being used to address PCN development needs.										
Working with people and communities	For the PCN	Approach agreed to engaging with local communities.		The PCN is engaging directly with their population and are beginning to develop trusted relationships with wider community assets.		PCNs are routinely connecting with and working in partnership with wider community assets in meeting their population's needs.		PCNs have fully incorporated integrated working with local Voluntary, Community and Social Enterprise (VCSE) organisations as part of the wider network.				
		Local people and communities are informed and there are routes for them contribute to the development of the PCN.		The PCN has undertaken an assessment of the available community assets that can support improvements in population health and greater integration of care.		Insight from local people and communities, voluntary sector is used to inform decision-making.		Community representatives, and community voice, are embedded into the PCNs' working practices, and are an integral part of PCN planning and decision-making.				
				The PCN has established relationships with local voluntary organisations and their local Healthwatch.		Community networks are understood and connected to the PCN.		The PCN has built on existing community assets to connect with the whole community and codesign local services and support.				

	For Systems	Systems are providing PCNs with expertise to support local involvement of people and communities.		Systems have put in place arrangements to support PCNs to develop local asset maps in partnership with their local community to enable models of social prescribing for personalised care.		Systems are facilitating effective partnerships with local community assets within PCN footprints.		The community assets and partnerships developed by PCNs are being connected in to strategic planning at place and system level.				
						The system is developing a strategy to support communities to develop and build particularly in those areas that face the greatest inequalities.						