Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

BNSSG Primary Care Commissioning Committee (PCCC)

Date: 29th October 2019
Time: 9.00am – 10:45am
Location: Vassall Centre, Gill Avenue, Bristol, BS16 2QQ

Agenda Number :	5
Title:	Primary Care Network Update
Purpose: Discussion	
Key Points for Discussion:	
This paper provides an update on the following: • Workforce baseline • PCN additional roles • Maturity matrices • Extended hours in PCNs • Organisational development and leadership in PCNs • The implementation of additional roles, the new guidance on additional roles, and the financial implications for the CCG.	
Recommendations:	The Committee is asked to note the findings from the PCN self-assessment, the proposed OD next steps and the implementation of additional roles.
Previously Considered By and feedback :	A PCN update was presented to PCCC in July 2019. This paper provides a further update.
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 in receipt of DES funding.
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 8.

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. An equality impact assessment will be necessary when designing organisational and leadership development programmes to ensure there is no negative impact on people with protected characteristics.
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.
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Agenda item: 5

Report title: Primary Care Network Update

1. Background

This paper aims to provide the committee with an update on progress in the engagement and development of the Primary Care Networks in BNSSG CCG following a previous report to the Primary Care Commissioning Committee in July 2019.

2. PCN Update

2.1 PCN Bulletin

A monthly PCN bulletin is written and distributed to all PCNs with updated contracting, financial and NHS England updates. Previous bulletins have included information on the new roles and expectations of NHS England, the data sharing agreements and the process for reimbursable roles sign off.

2.2 PCN Survey

A survey has been carried out to inform BNSSG CCG how PCNs would like to be contacted going forward (appendix 1), given the time pressures of the new PCN roles in Primary Care. As a result, there will be a mixture of face to face meetings quarterly and monthly teleconference calls with PCN Clinical Director and Manager representation.

2.3 PCN Organisational Development (OD) Co-design Event

An event was held for PCN Clinical Directors and Locality Leads on 2nd October 2019. The event had representation from all 17 out of 18 PCNs.

The purpose of the workshop was for the PCNs to reflect on their position on the maturity matrix and consider what was needed to progress through the matrix. A majority of PCNs had self-assessed themselves as being at ‘foundation stage’ or ‘pre-foundation stage’ of the matrix (appendix 2). PCNs have been asked to share their completed maturity self-assessment matrices with the CCG. To date 15 out of 18 self-assessments have been received and we are currently following up those which have not yet submitted. It is important that we understand the baseline to be able to support PCNs going forward. It was announced at the event that the system has a sum of £718K held by the CCG for PCN organisational development and leadership development. The purpose of the workshop was to identify what was needed to progress PCNs through the matrix, and identify PCN representatives from each locality (at the very least) to form a PCN OD Steering Group to take this work forward.

There were table discussions with each table representing a domain of the maturity matrix:

Leadership, Planning and Partnerships; Use of Data and Population Health Management; Integrating Care; Managing Resources; Working in Partnership with People and Communities .Summary from the workshop output is as follows:

Leadership, Planning and Partnerships

- Leadership development support
- Building on existing partnerships
- Shared outcomes with providers

Use of Data and Population Health Management

- Developing trust to share data
- How do we access data across all the practices in a PCN?
- How do we know what data is helpful?

Integrating Care

- We need trust to bring people to the ICS table
- How do we connect PCNs with Localities?
- PCNs need to drive the offer from partners

Managing Resources

- We need our priorities and roles designed; what are we here to do?
- Clarity regarding system plan to manage resources
- Digital investment is required

Working in Partnership with People and Communities

- PCN engages with community plan not vice versa
- Map assets and create links with the community
- Headspace to link infrastructure to GP practices

Next Steps

Following the PCN OD Co-design Event, the first meeting of the OD Steering Group, with representation from CDs and PCN Managers will take place in November 2019 via teleconference. This meeting will include attendance from the Primary and Community Care Training Hub, LMC, BNSSG CCG and OneCare to start the design of a bespoke PCN OD and Leadership Programme. It is anticipated that a series of workshops will need to be held to co-design the PCN support requirements including data, workforce and social prescribing. An OD programme plan will be shared with the CCG Executive Team and PCCC.

2.4 PCN Names

In September 2019, NHS England published a letter on their website: https://www.england.nhs.uk/wp-content/uploads/2019/09/letter-pcn-update-to-commissioners-robert-kettell.pdf which describes the naming conventions for PCNs as required by ODS, and has led to a review of the names of PCNs in BNSSG.

Naming convention summary:

PCN names will need to meet the following requirements:

- Include as a suffix the letters 'PCN'.
- Be limited to a maximum of 40 characters, including the suffix of 'PCN'.
- PCN names need to be as unique as possible and not simply be numbered to differentiate between them, (i.e. avoid use of 'North' or 'PCN1'). Introducing a geographic element to the name may help (i.e. 'Barking & Dagenham North PCN', rather than just 'North PCN').
- If required, numbering PCNs whilst including the CCG area name should be acceptable, as they should still be nationally unique names (i.e. 'Durham Dales (1) PCN' and 'Durham Dales (2) PCN' etc.
- We recommend expanding acronyms for clarity (i.e. WACA, APL) if the 40-character limit allows. The PCN acronym is acceptable as the expansion of PCN will be included in ODS role reference data.
- Standard practice would be to use 'and' in organisation names if required, but '&' can be used in the PCN name if it is reaching/exceeding the 40-character limit

As a result, the current list of PCNs which was presented to PCCC in July 2019 is in the process of being updated, and will be shared with PCCC once completed and agreed with NHS England.

3. Extended Hours

All PCNs have submitted plans to deliver their required share of minutes in July 2019. Following the closure of Bishopston and Northville practices Phoenix PCN will be asked to re-submit their plan. Practices are asked to declare the number of appointments offered, attended and the number of DNAs on a quarterly basis. Practices who had historically not delivered Extended Hours have been working with One Care to mobilise plans to deliver alongside Improved Access. Extended hours generates >500 additional hours of primary care capacity per week across BNSSG.

4. PCN Baseline Sign Off and Additional Roles Guidance

4.1 PCN Baseline

A baseline of the reimbursable roles' workforce in BNSSG's PCNs was collected by BNSSG CCG in June 2019. To ensure the data adequately reflected the workforce position against the reimbursable roles claims, there was a request from NHS England for the Clinical Directors of all PCNs in BNSSG to approve and sign off their

baseline by 24th September 2019. This process was completed and the updated CD approved baseline has been submitted to NHS England. The new roles will have to provide 'additionality' in the system, hence the importance of an accurate baseline.

4.2 Clinical Pharmacists Previously on NHS England Clinical Pharmacist Scheme

Confirmation is being sought from NHS England on BNSSG Pharmacists who have officially transferred across from the NHS England Clinical Pharmacist scheme to PCNs as well as those who remain on the existing scheme. NHS England has confirmed that 4 PCNs in BNSSG have transferred staff from the clinical pharmacist training scheme across to their PCN by the deadline of 30 September 2019.

PCNs will need to consider the impact of the change in funding arrangements from 2020/21. All Pharmacists who have moved over from the NHSE Clinical Pharmacists Scheme to the PCN will need to be funded from the total reimbursable sum from 2020, in addition to any new PCN roles they wish to fund. Physiotherapists and Physicians Associates are included in the reimbursable roles from April 2020 and Paramedics are included from 2021.

4.3 Additional Roles Funding (National Guidance Update)

Guidance for additional roles was published by NHS England in August 2019:

https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-additional-roles-reimbursement-scheme-guidance/

Maximum Reimbursable Amounts for Additional Roles 2019-2024 (NHS England)

TABLE 1

	AfC Band	**% Reimbursement**	**Maximum annual reimbursable amount (£)**			
ROLE			**2020/21**	**2021/22**	**2022/23**	**2023/24**
Clinical Pharmacists	7-8a	70%	38,969	39,844	40,657	41,487
Social Prescribing Link Worker	Up to band 5	100%	35,389	36,193	36,941	37,703
Physiotherapist	7-8a	70%	38,969	39,844	40,657	41,487
Physicians Associate	7	70%	37,607	38,452	39,237	40,039
Paramedic	6	70%	N/A	31,479	32,125	32,784

Indicative Additional Roles Reimbursement Sum allocations for different PCN sizes from 2020/21 to 2023/24 (NHS England)

TABLE 2

	2019/20	2020/21 (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)
Total National Workforce Funding	**Maximum reimbursable amount in 2019/20 (equivalent to 9 months) (£)**	257M	415M	634M	891M
PCN Size (Weighted)					
15,000	53,942.25	74,358	104,400	159,900	224,200
20,000	53,942.25	86,200	139,200	212,700	298,900
25,000	53,942.25	107,800	174,000	265,900	373,600
30,000	53,942.25	129,300	208,800	319,000	448,300
40,000	53,942.25	172,400	278,400	425,400	597,800
50,000	53,942.25	215,500	348,000	531,700	747,200
80,000	53,942.25	344,900	556,900	850,700	1,195,600
100,000	107,884.50	431,100	696,100	1,063,400	1,494,500
150,000	161,826.75	646,600	1,044,100	1,595,100	2,241,700

5. PCN Additional Reimbursable Roles Process in BNSSG CCG

5.1 Recruitment Process in BNSSG

A process was put in place for BNSSG PCNs to submit their plans to BNSSG CCG before recruiting to the roles to ensure they met the reimbursable roles criteria. The process ensures oversight from the contracts team, finance team, primary care development team and area teams, with a response from the contracts team within 5 working days of submission (appendix 3).

5.2 Additional Roles Funding BNSSG Current Position

PCNs were able to employ Clinical Pharmacists and Social Prescribing Link Workers from 1st July 2019. The first tranche of reimbursable roles claims are due to be paid at the end of October 2019. These are backdated to July 2019 where applicable

Twelve PCNs have had Social Prescribing Link Worker plans signed off in principle. Any reimbursement is subject to further checks to ensure funding is released in line with the respective PCN entitlements and only for staff who are additional to the baseline.

The CCG has received claims for 9.3 whole time equivalent Clinical Pharmacists from three PCNs to date, with further implementation of Clinical Pharmacist PCN roles to follow. A further six PCNs have requested the CCG to review Clinical Pharmacist job descriptions before progressing to recruitment.

5.3 Additional Roles Underspend

Guidance was published by NHS England in August 2019 regarding CCGs' assessment of reimbursement claims from PCNs, including the principles for additionality. The guidance also sets out the actions that PCNs and CCGs are expected to take if they are not planning to use the full additional roles reimbursement funding in 2019/20, and clarifies that additional roles reimbursement funding cannot be used outside the terms of the DES (including, for example, higher levels of reimbursement or reimbursement for costs not specified in the DES).

Locally, the CCG has supported PCNs to recruit to additional roles on a pro rata basis in advance of their combined allowance being made available from next April which will be pro rata to list size. There will be no additional funding made available from the CCG from this point onwards.

NHS England 'strongly encourages' CCGs to put in place local schemes to share the unused financial entitlement across the other PCNs in the area to enable them to carry out further recruitment, on the terms set out in the Network Contract DES and in the guidance, above their 2019/20 entitlement (with those further additional posts then attracting national funding via the Additional Roles Reimbursement Sum for 2020/21).

As part of the agreed financial plan for 2019/20, there is already an assumption that there will be 50% slippage on the maximum roles reimbursement. This was necessary in order to submit a balanced financial plan.

Work is on-going to further understand the forecast expenditure on additional roles this year, which will be developed and shared with the CCG Executive Team and the Committee by the end of this calendar year. It is not anticipated that there will be a significant level of uncommitted funding in 2019/2020.

For 2020/21 and beyond, NHS England intends to discuss with GPC England and primary care commissioners the introduction of a national system of entitlements for PCNs to claim unused Additional Roles Reimbursement Scheme funding from other PCNs' unused entitlements within a CCG area. This would enable those PCNs which have made swift progress in recruiting to the additional roles set out in the Network Contract DES to bring forward further recruitment plans from the subsequent year.

6. Future Monitoring of PCNs

6.1 Network Dashboard and Impact and Investment Fund

There will be a PCN dashboard introduced in 20/21 along the introduction of the Network Dashboard and the Impact and Investment Fund which will complement service requirements. The service specifications will set minimum requirements within the DES. The dashboard will include measures of success to allow PCNs to

benchmark their performance and monitor their delivery of the five service specifications, due to be published in early 2020.
The Impact and Investment Fund (IIF) is expected to provide additional funding to PCNs which go further and faster to deliver the national service specifications and provide an incentive for PCNs to reduce unwarranted demand on NHS services, including overprescribing and inappropriate A&E attendances. The IIF is expected to commence in April 2020, and will develop over the subsequent four years following further engagement and discussion. NHS England is developing proposals for the first year of the operation of the IIF, ahead of formal contract discussions with GPC England.

7. Next Steps and Recommendations

7.1 Next Steps

- The first meeting of the PCN OD Steering Group will take place in November 2019
- There will be quarterly meetings with PCN CDs and managerial leads
- Monthly PCN bulletins will continue to be shared with PCNs
- A more detailed PCN update will be presented to the closed PCCC session in November 2019

7.2 Recommendations

The Committee is asked to note:

- the findings from the PCN self-assessment
- the proposed OD next steps
- the implementation of additional roles, the new guidance on additional roles, and the financial implications for the CCG.

8. Financial resource implications

The total funding envelope for Primary care Networks is set out in the table below, these are funded from the CCGs notified Delegate Primary Care resource allocation, with the exception of the Core PCN finding, which is funded from the CCGs Core Programme allocation

Primary Care Network
Funding 2019/20

TABLE 3

Clinical Pharmacists	* max of 1.00 WTE per 30,000 (Weighted)	£910K
Social Prescribing Link Workers	* max of 1.00 WTE per 30,000 (Weighted)	£821K

Clinical Director	0.25 WTE per 50,000 (registered)	£525K
Extended Hours Access DES	£1.099 per registered patient (from July)	£1,122K
Core PCN Funding	£1.50 per weighted patient	£1,531K
Network Participation Payment	£1.761 per weighted patient	£1,696K

In addition to the above funding, the CCG has received an additional £718K non-recurrent funding as part of GP Forward View (GPFV) allocations PCN organisational and leadership development.

9. 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.

10. Risk implications

Risk	Mitigating Actions	Current Score	Target Score
If PCNs are not resilient they will be unable to deliver Primary Care plans that support system wide transformation	• Internal Communications plan to be further built on and implemented • Wider stakeholder engagement plans to be developed • Links with Urgent Care Strategy/UTCs • Locality Development Plans • Healthy Weston model of care development supporting PCN development • Communication Strategy • GP resilience tool to be applied to support PCNs • PCN Organisational Development Plan to be produced in partnership with Clinical Directors	3x4	2x4

11. 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.

12. How does this impact on Equality and Diversity?

There have been no implications for equality and diversity identified. An equality impact assessment will be necessary when designing organisational and leadership development programmes to ensure there is no negative impact on people with protected characteristics.

13. 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.

Glossary of terms and abbreviations

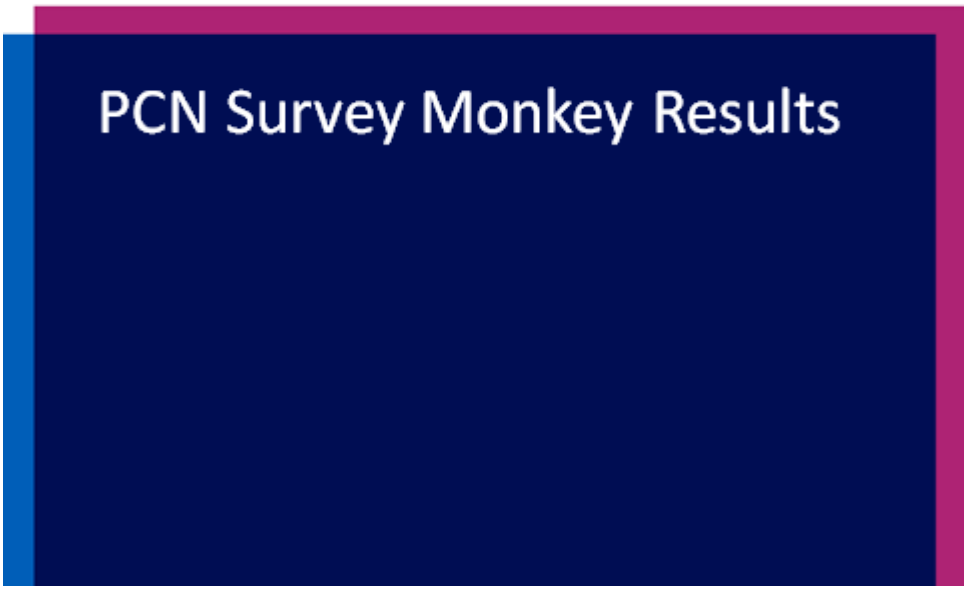
PCNs	Primary Care Networks are groups of GP practices working collaboratively in a formalised structure, typically covering a population of 30,000 to 100,000 patients, and combining with other primary and community services and local organisations to ensure an integrated approach to health and care for 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
ICS	Integrated Care System. 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.

Appendices

Appendix 1

PCN Communication Survey Monkey Results

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group



What you've told us so far.. (PCN Clinical Director Survey Monkey)

- You would prefer us to contact you via teleconference when we want to discuss and agree proposals with you
- You would prefer to receive updates such as letters and information about key deadlines by email
- You would rather receive updates 'as and when' rather than at a set time eg fortnightly
- You would prefer these updates to come to your Clinical Director and Practice Manager from lead practice to cover for periods of leave etc

We asked to extend the monthly locality provider leads meetings to all PCN Clinical Directors on a quarterly basis. You said...

- As long as meetings have a purpose 92% of CDs are in agreement
- Give as much notice as possible for meetings
- It can be difficult having Locality Provider Leads and PCN Clinical Director both out of the practice at the same time
- Bi-monthly rather than quarterly would be better in the first year

We plan to establish a PCN OD Working Group made up of PCN representatives from each locality. You said..

- 92% of CDs agree with a PCN working group made up of PCN representatives from each locality
- 8% felt that if key groups are discussing issues that are relevant to or impact PCNs then PCNs should be represented by themselves on key groups. "Locality and PCN are not synonymous".

Appendix 2
Maturity Matrix

PCN Maturity Matrix

NHS

	Foundation	Step 1	Step 2	Step 3
Leadership, planning and partnerships Prospectus Domains: Leadership, OD, Change management, CD leadership	For PCNs: • 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. • Clinical directors are able to access leadership development support. 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. • 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.	For PCNs: • The organisations within the PCN have agreed shared development actions and priorities. • 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. • 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: • Primary care is enabled to have a seat at the table for system and place strategic planning. • 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.	For PCNs: • 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. • The PCN Clinical Director is working with the ICS/STP leadership to share learning and support other PCNs to develop. For Systems: • 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. • PCN Clinical Directors work with the ICS/STP leadership to share learning and work collaboratively to support other PCNs.	For PCNs: • 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. For Systems: • 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.
Use of data and population health management Prospectus Domain: Population Health Management	For PCNs: • The PCN is using existing readily available data to understand and address population needs, and are identifying the improvements required for better population health. 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.	For PCNs: • Analysis on variation in outcomes and resource use between practices and PCNs is readily available and acted upon. • 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 • Data and soft intelligence from multiple sources (including and wider than primary care) is being used to identify interventions. For Systems: • Basic data sharing, common population definitions, and information governance arrangements have been established that supports PCNs with implementation of PHM approaches. • There is some linking of data flows between primary care, community services and secondary care.	For PCNs: • 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. • Functioning interoperability within networks, including read/write access to records,. For Systems: • 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 • 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.	For PCNs: • 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. • Ongoing systematic analysis and use of data in care design, case management and direct care interactions support proactive and personalised care For Systems: • Full interoperability is in place across the organisations within PCNs, including shared care records across providers. • 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.

NHS England and NHS Improvement

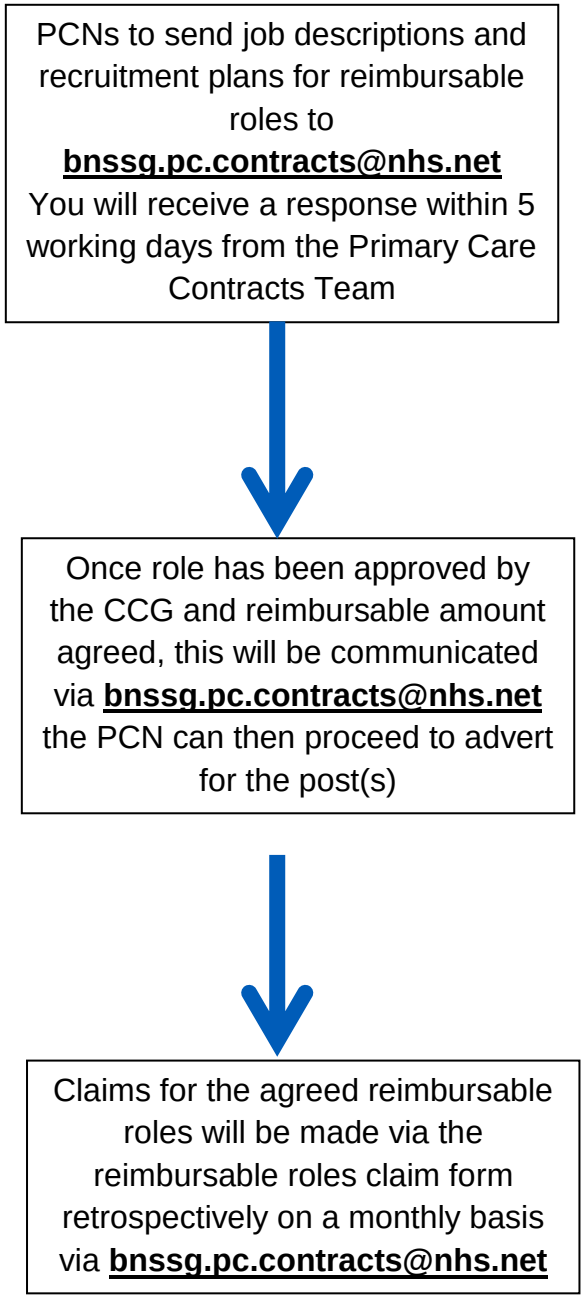
PCN Maturity Matrix

NHS

	Foundation	Step 1	Step 2	Step 3
Integrating care Prospectus Domain: Collaborative Working (MDTs)	For PCNs: • 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. • 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. 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.	For PCNs: • 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. • Components of comprehensive models of care are defined for all population groups, with clear gap analysis and workforce plans. For Systems: • Systems support the building of relationships across providers of physical and mental health services, and social care partners. • System workforce plans supports the development of integrated neighbourhood teams.	For PCNs: • 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. • 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. For Systems: • 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.	For PCNs: • 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. • There are fully interoperable IT, workforce and estates across the PCN, with sharing between networks as needed. For Systems: • Systems have developed and implemented integrated care models that meet with objectives of the LTP.
Managing resources	For PCNs: • Primary care, in particular general practice, has the headroom to make change • 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. • PCN development support funding is being used to address PCN development needs.	For PCNs: • 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. For Systems: • 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.	For PCNs: • The PCN has sight of resource use and impact on system performance and can pilot new incentive schemes where agreed locally. For Systems: • Systems support networks to have sight of resource use and impact on system performance and that can enable piloting of new incentive schemes.	For PCNs: • 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. For Systems: • 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.
Working in partnership with people and communities Prospectus Domain: Asset based community development & social prescribing	For PCNs: • Approach agreed to engaging with local communities. • Local people and communities are informed and there are routes for them contribute to the development of the PCN. For Systems: • Systems are providing PCNs with expertise to support local involvement of people and communities.	For PCNs: • The PCN is engaging directly with their population and are beginning to develop trusted relationships with wider community assets. • The PCN has undertaken an assessment of the available community assets that can support improvements in population health and greater integration of care. • The PCN has established relationships with local voluntary organisations and their local Healthwatch. For Systems: • 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.	For PCNs: • The PCN is routinely connecting with and working in partnership with wider community assets in meeting their population's needs. • Insight from local people and communities, voluntary sector is used to inform decision-making. • Community networks are understood and connected to the PCN. For Systems: • Systems are facilitating effective partnerships with local community assets within PCN footprints. • The system is developing a strategy to support communities to develop and build particularly in those areas that face the greatest inequalities.	For PCNs: • The PCN has fully incorporated integrated working with local Voluntary, Community and Social Enterprise (VCSE) organisations as part of the wider network. • Community representatives, and community voice, are embedded into the PCN's working practices, and are an integral part of PCN planning and decision-making. • The PCN has built on existing community assets to connect with the whole community and codesign local services and support. For Systems: • The community assets and partnerships developed by PCNs are being connected in to strategic planning at place and system level.

NHS England and NHS Improvement

Appendix 3
Reimbursable Roles Process for PCNs



Internal CCG Process Reimbursable Roles for PCNs