Primary Care Networks OGIM 2021/22

Why change is needed

- It is estimated that around 90% of NHS contacts take place in primary care, with approximately 8,700 patient contacts per day (over 3 million per year) in general practices across County Durham.
- In January 2019, NHS England published the NHS Long Term Plan setting out the overarching long-term goals for the NHS and specific changes for Primary Care through dissolving the divide between primary care and community-based health services. Building on the ambitions set out in the NHS Five Year Forward View and The General Practice Forward View, the plan emphasises a shift of focus away from hospitals and towards community and primary care and acknowledges the challenges currently being faced in General Practice.
- Primary Care Networks (PCNs) were formed in July 2019. They are groups of GP practices, working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas.
- The expectation is that PCNs will be a key vehicle for delivering many of the commitments in the long-term plan and providing a wider range of services to patients. https://www.kingsfund.org.uk/publications/primary-care-networks-explained
- In February 2021, the Department of Health and Social Care published the White Paper Integration and innovation: working together to improve health and social care for all, which sets out legislative proposals for a health and care Bill. Grouped around themes of working together and supporting integration; stripping out needless bureaucracy; enhancing public confidence and accountability; and additional proposals to support public health, social care, and quality and safety, these proposals represent a shift away from the focus on competition towards a new model of collaboration, partnership and integration.
- The development and maturation of our PCNs is critical to the ambitions set by NHS England. For our PCNs to effectively deliver their commitments it is essential that they flourish, with well-formed networks with strong and capable leadership, ensuring effective integration with their partners.

Objectives

- PCNs to develop to full maturity
- PCNs to deliver the Network Contract DES and associated service specifications (see below)
- PCNs to go further than the requirements of the Network Contract DES, where possible, building upon the foundation built in County Durham, to ensure the effective co-ordination of integrated services at 'Place'.
- PCNs to work with partners to provide a fully integrated health and social care system without visible boundaries

Goals

PCNs are the footprint around which integrated community-based teams are developed, with community and mental health services configuring their services around PCN boundaries. These teams will provide services to people with more complex needs, providing proactive and anticipatory care.

1. PCNs are required to deliver on the Network Contract DES. This will eventually include a set of seven national service specifications: Structured medication reviews, enhanced health in care homes, and supporting early cancer diagnosis are already live. A further four will follow - anticipatory care (with community services), personalised care, cardiovascular disease case-finding, and locally agreed action to tackle inequalities. To achieve delivery on these our networks will:
    a. Provide a wider range of primary care services to patients, involving a wider set of staff roles such as first contact physiotherapists, paramedics and social prescribers.
    b. Look at the wider health of their population, taking a proactive approach to managing population health and assessing the needs of their local population to identify people who would benefit from targeted, proactive support.
    c. Increase the scale of multi-agency integration to reduce health inequalities and improve our population health outcomes.
    d. Support better health through prevention and develop a culture that promotes self-care.
    e. Develop new models of proactive, co-ordinated and personalised care that promote shared decision making to ensure high quality care is delivered closer to home. This approach will ensure hospital stays are seen as part of a continuing relationship with care services and not an isolated episode.
    f. Ensure that patients will continue to have a named GP who is accountable for their care but may be supported and treated by another member of the extended multi-disciplinary team who can best meet their needs.
    g. Build on the success of their collaborative working during COVID and the COVID vaccination programme.
2. Each PCN is being supported in their development with dedicated input from the CCG plus PCN Development funding.
    a. PCNs are utilising a Maturity Matrix, designed to support network leaders, working in collaboration with systems, places and other local leaders within neighbourhoods. This will help them understand the development journey both for individual networks, and how groups of networks can collaborate across a place in the planning and delivery of care.
    b. The Maturity Matrix is organised in the following components:
        i. Leadership, planning and partnerships
        ii. Use of data and population health management
        iii. Integrating care
        iv. Managing resources
        v. Working in partnership with people and communities

COVID - 19

SARS-CoV-2, better known as Coronavirus or COVID-19, is arguably one of the greatest public health challenges of our time – not least for general practice. Due to the pandemic, general practice had to change how it operates overnight. Over recent months primary care has shown an extraordinary resilience, capacity for innovation and ability to move quickly for our patients. We now face the double challenge of continuing to operate in a world with COVID-19 while also responding to the urgent non-COVID needs of our patients and their local communities.

The COVID-19 pandemic has impacted disproportionately on certain groups of our population, namely our older population; those with existing underlying health conditions such as diabetes and obesity; our BAME (black and minority ethnic) population and those living/working in more disadvantaged circumstances.

COVID-19 has also had a significant impact on the way that health and care services are delivered to people in County Durham and it is likely that the impact will be ongoing for some time as long as COVID-19 remains a risk to health.

As part of our response to COVID-19, we were required to mobilise some urgent system changes, based on advice from NHS England, to release clinical staff from primary care to work in other health settings and to support patients where needed, which included:.

- a move to a 'triage first' model and greater use of online and video consultations
- setting up COVID secure hubs, to ensure that patients with COVID could still access treatment, whilst safeguarding staff and patients
- delivering a package of support to care homes ahead of the Network Contract Direct Enhanced Service (DES) requirements.

To ensure that the positive transformative changes are not lost, we must take steps to lock-in these improvements moving forward. As part of our refreshed primary care strategy and COVID-19 recovery planning we will take into consideration the following dimensions:

- Embedding COVID driven transformation
- Managing the backlog of pre-COVID patients, whose treatments were delayed
- Building resilience for future COVID waves
- Reducing health inequalities
- Long COVID

Triple Aim Outcome Measures

Partnership Board - Primary, Community & Social Care Group		
Health Outcomes	**Patient Experience Outcomes**	**Workforce Outcomes**
1. Proportion of people with a learning disability on the GP register receiving an annual health check	1. National GP survey (annual)	1. Number of GPs employed by NHS (CCG level data)
2. Increase uptake of screening programmes (breast, bowel and cervical)	2. GP contract / Primary Care Network Patient reported access measure – measure to be confirmed*	2. Number of FTEs, above baseline, in the Primary Care Network additional role reimbursement scheme
3. Delivery of structured medication reviews	3. Patients whose care has been discussed as part of shared decision making	3. Proportion of providers with an outstanding or good rating from the CQC for the "well led" domain

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRA
1. Health Inequalities						
Implementation of DES service specification – Early Cancer Diagnosis						
Implementation of DES service specification – Structured Medication Review and Medicines Optimisation						
Flu and COVID 19 vaccination preparedness and addressing vaccine inequalities						
Utilisation of Population Health Management in conjunction with Public Health and other relevant partners to inform PCN's understanding of population health needs						
Implementation of DES service specification – CVD diagnosis and prevention						
Implementation of DES service specification – Tackling health inequalities						
2. Health Behaviours (Alcohol, Tobacco, Nutrition and Physical Activity)						
Strengthen links between Primary Care and ICS Prevention Board and associated workstreams						
Encourage patient/public engagement to support co-production of health behaviour initiatives						
3. Personalised Care						
Full implementation of the Framework for Enhanced Health in Care Homes – seven care elements						
Primary Care input into system wide planning for recovery and preparing for future COVID waves						
Implementation of DES service specification – personalised care postponed by NHSE						
Implementation of DES service specification – anticipatory care postponed by NHSE						
Promote the ARRS Personalised Care roles, to increase uptake in PCNs, and support self-care						
4. Mental Health and Learning Disabilities						
Deliver physical health checks for people with Serious Mental Illness (SMI)						
Improve accuracy of GP LD Registers for the identification and coding of patients						
Improve number of annual health checks with people living with learning disabilities						
Recruit to PCN workforce additional role – new Mental Health practitioners (adults and children & young people – where available)						
5. Children						
Support PCNs with any specific improvement projects						
Development of PCN Children's Health Visiting team						
6. Digital						
Virtual Consultation – embedding of digital solutions in line with the regional strategy						
7. Finance						
Maximise use of Additional Roles Reimbursement Scheme						
Local Integration and Improvement Scheme (LIAISe) - refreshed annually to reflect local needs and national priorities						
IIF - Support primary care on implementation of work to support achievement against IIF indicators						
8. Integration						
Primary Care Workforce plan including training and development of expanded multi-disciplinary team working						
Ongoing PCN development as part of an integrated system approach, underpinned by PCN Development Funding						
Implementation of the DES service specification – Enhanced Health in Care Homes						
9. Cultural Change						
Embedding transformation post COVID, e.g. efficient and appropriate use of telephone triage and on-line consultations						
Care Navigation – understand how this will fit with post COVID transformation						
Continue to support the cultural shift from separate primary, community and social care services towards integrated Primary Care Networks through the organisational development programme						
Engage with patients/public around 'most appropriate health professional' agenda						