

Primary care networks explained

What are primary care networks?

Primary care networks (PCNs) are a key element in the [NHS long term plan](#), which set out the NHS' ambition to boost 'out-of-hospital' care and dissolve the historic divide between primary and community health services. The plan recognised, however, that achieving these ambitions requires significant action to overcome the severe workforce crisis in general practice and tackle the pressures facing GPs and primary care.

A PCN consists of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. GP practices are not mandated to join a network, but they will miss out on significant funding if they choose not to. If a practice does not sign up to a network its patient list will nonetheless be added into one of its local PCNs to ensure all patients have access to network services.

The long term plan says that PCNs are normally based around natural local communities typically serving populations of at least 30,000 and not tending to exceed 50,000. PCNs are intended to be small enough to maintain the traditional strengths of general practice and continuity of care, but at the same time large enough to provide resilience and support the development of integrated teams.

PCNs will be expected to have a particular focus on prevention, population health and addressing health inequalities in their local area. They will also have an important role to play in delivering personalised care, for example, link workers within PCNs will work with people to develop tailored plans and connect them to local groups and support services through social prescribing.

While GPs will be leading PCNs, the ambition is for PCNs to employ 'enhanced neighbourhood teams' comprising a range of health care professionals including pharmacists, district nurses, community geriatricians, dementia workers and allied health professionals such as physiotherapists and podiatrists/chiropractors, joined by social care and the voluntary sector. These bigger teams of health professionals, working as part of community teams, will provide tailored care for patients and allow GPs to focus more on patients with complex needs. District nursing will also be organised on the same geographic footprints as PCNs across the country.

While GP practices have been working together through a variety of models over many years these collaborations have tended to be informal arrangements, so PCNs will put a more formal structure around this way of working. However PCNs will not necessarily replace other models of collaboration such as GP federations; NHS England has said that GP federations and PCNs are not mutually exclusive and can co-exist to deliver a broader set of integrated out of hospital services for their local communities.

Without a formal organisation or structure representing general practice, GPs have historically found it difficult to have an influential role in planning across health and care systems, most recently in sustainability and transformation partnerships (STPs) and integrated care systems (ICSs). PCNs could help boost primary care engagement, not least because each PCN clinical director will have a seat on ICS partnership boards.

All PCNs are expected to be registered by 30 June 2019. PCNs will be able to deliver services, employ staff and receive funds through the new [primary care contract](#) which will then come into place from 1 July 2019 as a Directed Enhanced Service (DES). The contract commits to major investment in general practice: by 2023/24, the contract is expected to invest £1.799 billion, or £1.47 million per typical PCN covering 50,000 people. This will include funding for around 20,000 more health professionals.

Clinical commissioning groups (CCGs) (or local NHS England teams for the small number of CCGs without delegated primary care commissioning), will be responsible for overseeing the contract registration process and for the ongoing assurance of PCNs' delivery against the requirements of the contract.

The primary care contract also includes new initiatives on indemnity and pensions that are critical to improving the recruitment and retention of GPs. It also commits to investment in IT including email and video consultation, improved access to records and electronic prescribing.

The roll out of PCNs will have a number of implications for NHS trusts and foundation trusts. Community services are expected to form part of a PCN and 'align' around PCNs footprints. For some areas where there has historically been little engagement between primary care and other services, or where the PCN model is a significant move away from existing approaches to collaboration, this is likely to require local health care leaders to develop new relationships and new ways of working. For NHS providers, it may initially be unclear who a trust needs to engage with at a PCN. Given it will take time to develop relationships and an aligned vision for health and care services for the local population, the short timescales for setting up PCNs may be particularly challenging for some areas.

It is also important that PCNs are set up on geographic footprints that make sense to local people and allow collaboration with existing models of collaboration such as STPs and ICSs.

As PCNs begin to recruit healthcare professionals to work in multidisciplinary teams, it is crucial that this is done in collaboration with providers and other partners and based on a shared local vision. The shortages among some groups of healthcare professionals means there is a danger that recruitment into PCN roles will result in workforce gaps elsewhere, particularly roles such as pharmacists, paramedics and occupational therapists.

Some parts of the country have already introduced new ways of working in line with the approach intended for PCNs. For example, [Dorset](#) is using the Primary Care Home model to bring GPs together to work in locality groups, embed new care models for frailty, long term conditions such as diabetes, develop plans on estates and technology and deliver improved access to general practice.

The development of PCNs are an exciting opportunity for local services and populations to come together to identify how people can be supported to stay healthy and to develop truly integrated models of care that offer personalised, coordinated health and care support. It will be important for NHS trusts to work with PCNs as they develop to ensure there is alignment around existing services and plans for integration, a joint approach to workforce and to manage issues around governance and contracting. Governors can use their holding to account duty to question how their trust is engaging with PCNs by asking:

- How is the board facilitating positive and collaborative relationships with external PCN partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?
- What assurances do NEDs have that the trust will be able to work in partnership with PCNs around recruitment to ensure the local workforce, and local recruitment strategies are not destabilised?
- How might the introduction of PCNs benefit (or pose risks to) existing local programmes of work to integrate care?
- How is our region communicating with national bodies such as NHS England and NHS Improvement to help spread learning and support the development of PCNs nationally?

For further information about PCNs visit the NHS England [website](#).

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