Healthier **Together**

Improving health and care in Bristol,
North Somerset and South Gloucestershire

Primary Care Network Development

Sponsoring Board 21st March

NHS Long Term Plan

- Expanded community multidisciplinary teams aligned with new Primary Care Networks based on neighbouring GP practices
- Individual practices in a local area will enter into a network contract, as an extension of their current contract, and have a designated single fund through which all network resources will flow.
- Expanded neighbourhood teams will comprise a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and AHPs such as physiotherapists and podiatrists/chiropodists, joined by social care and the voluntary sector.

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Primary Care Networks

- Essential building block of Integrated Care Systems.
- Typical population of 30-50,000 with geographical coverage by July 2019. 50,000 is a suggested upper level, not a strict requirement.
- PCN must have boundary that makes sense to : a) Its constituent practices; (b) to other community-based providers , who configure their teams accordingly ; and (c) to its local community.
- Introduction of a new Network Contract – this is a **Directed Enhanced Service (DES)** backed by financial entitlements.
- Each Network will have a named **accountable Clinical Director**.
- Integrated Care Systems will have a critical role in ensuring that PCNs work in an integrated way with other community staff such as community nurses, community geriatricians, dementia workers, and podiatrists/chiropodists.

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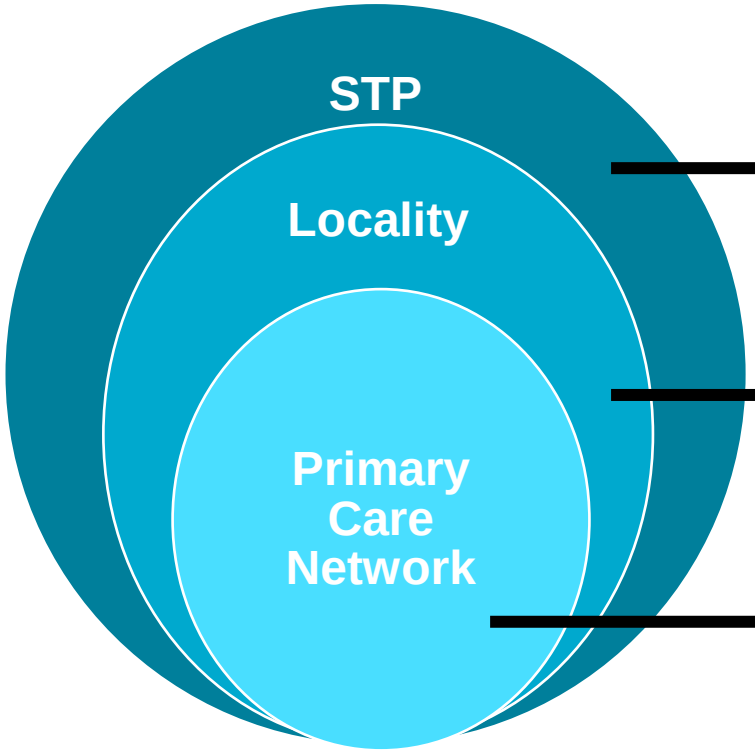
Primary Care Networks (PCNs) are a great opportunity…

- Providing stability within a five year framework
- Directing significant new resources to primary care to support resilience and accelerate working together
- Enabling ownership at a level where people:
  - know their patients/population
  - know each other
  - can work together and get stuff done
- Supporting new service delivery and joined-up care, for both physical and mental health, across a wider primary care team
- Building on what we've achieved over the last few years through clusters and localities
- Supporting mobilisation of the new model for community services
- Laying the foundation for wider system transformation

...forming the building block of integrated care



Long term plan	Function
Integrated Care System (ICS)	Strategic
Integrated Care Partnerships (ICP) Provider Alliance	Planning and coordination across providers
Primary Care Networks	Resilience Local Delivery Shared Resource

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Primary Care maturity matrix

	Foundations for transformation	*Step 1*	*Step 2*	*Step 3*
Right scale	**Plan:** Plan in place articulating clear vision and steps to getting there, including actions at network, place and system level.	**Practices identify PCN partners** and develop shared plan for realisation.	PCNs have **defined future business model** and have early components in place.	**PCN business model** fully operational.
Integrated working	**Engagement:** GPs, local primary care leaders and other stakeholders believe in the vision and the plan to get there.	**Analysis on variation** in outcomes and resource use between practices is readily available and acted upon.	Functioning **interoperability within networks,** including read/write access to records, sharing of some staff and estate.	**Fully interoperable IT, workforce and estates** across networks, with sharing between networks as needed.
Targeting Care	**Time:** Primary care, in particular general practice, has the headroom to make change.	**Basic population segmentation** is in place, with understanding of needs of key groups and their resource use.	All primary care clinicians can access **information to guide decision making**, including risk stratification to identify patients for proactive interventions, IT-enabled access to shared protocols, and real-time information on patient interactions with the system.	**Systematic population health analysis** allowing PCNs to understand in depth their populations' needs and design interventions to meet them, acting as early as possible to keep people well.
Managing resources	**Transformation resource:** There are people available with the right skills to make change happen, and a clear financial commitment to primary care transformation.	**Integrated teams**, which may not yet include social care and voluntary sector, are working in parts of the system.	Early elements of **new models of care** in place for most population segments, with **integrated teams** throughout system, including social care, the voluntary sector and easy access to secondary care expertise. Routine peer review.	**New models of care** in place for all population segments, across system. Evaluation of impact of early-implementers used to guide roll out.
Empowered Primary Care		Standardised end state **models of care** defined for all population groups, with clear gap analysis to achieve them.	**Networks have sight of resource use and impact on system performance**, and can pilot new incentive schemes.	PCNs take **collective responsibility for available funding.** Data being used in clinical interactions to make best use of resources.
		Steps taken to ensure **operational efficiency** of primary care delivery and support struggling practices.	Primary care plays an **active role in system tactical and operational decision-making,** for example on UEC	**Primary care providers** full decision making member of ICS leadership, working in tandem with other partners to allocate resources and deliver care.
		Primary care has a **seat at the table** for system strategic decision-making.		

GP Contract – a 5 Year Framework

- Indemnity Scheme
- Primary Care Networks
- New Workforce
  - Clinical pharmacists
  - Social prescribing link workers
  - Physician associates,
  - First contact physiotherapists
  - First contact community paramedics
- Network Services
  - Structured Medications Review and Optimisation;
  - Enhanced Health in Care Homes, to implement the vanguard model;
  - Anticipatory Care requirements for high need patients typically experiencing several long term conditions
  - Personalised Care
  - Supporting Early Cancer Diagnosis;
  - CVD Prevention and Diagnosis; and
  - Tackling Neighbourhood Inequalities.

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We have already achieved a lot...

- **Clusters:** involving primary, community and voluntary sector providers
- **Digital:** Ask My GP, sharing appointments between GP practices using EMIS platform
- **IA:** delivered by localities
- **Test bed programme:** delivering new services - e.g. mental health in primary care, clinics in practice at the weekend (CAB/Drugs and alcohol), mental health services for teenagers, new community nurse visiting service, locality wide social prescribing plan
- **Localities:** driving change as part of Healthier Together – e.g. the Weston Frailty Model

GP Practice Clusters

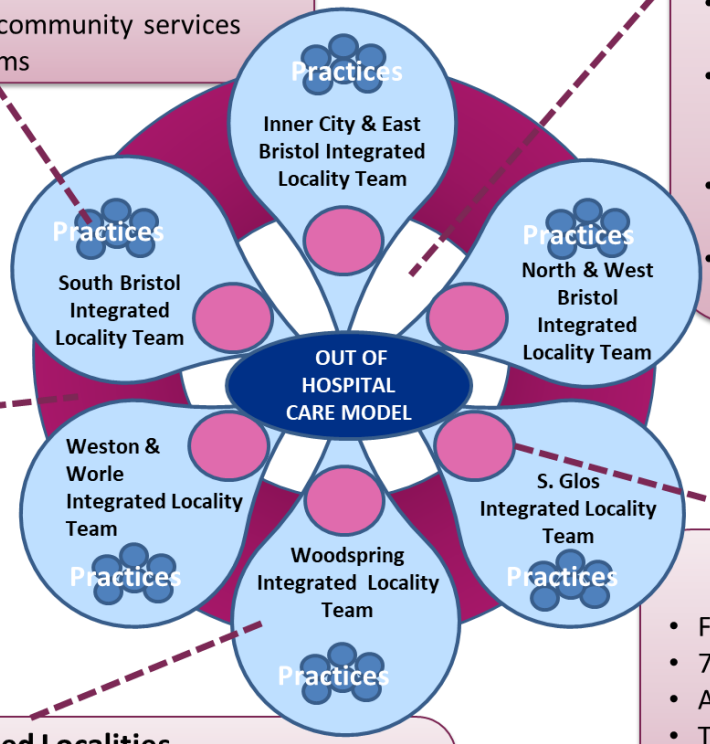
- Collaboration across practices
- Leading locality hubs
- Leading and directing community services integrated locality teams

Specialist advice and support

- Small number of highly trained specialists
- Educational input to core community services and primary care
- Advice and care for complex cases
- Linked to acute speciality teams

Intermediate Care

- Integrated across hubs & localities
- 24/7 rapid response
- In-hospital liaison and pro-active discharge support
- Specialised in catheter care & complexity
- Access to community beds and IV therapies



Locality Hubs

- Frailty management
- 7 day primary care
- Ambulatory Care
- Treatment rooms
- Access to diagnostics

Integrated Localities

- Working across primary care, community and hubs through regular multidisciplinary team meetings
- Includes district nursing, community therapies, dietetics, podiatry and orthotics, speech and language, domiciliary phlebotomy, urinalysis and blood pressure

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The Healthier Together Ambition

- **To build an entirely new model of local integrated care to help people stay independent, healthy and well in the community…**

- Frailty hubs and integrated frailty services
- Diagnostic/urgent care hubs
- Mental health services integrated at locality level
- Community mobilisation and securing new routes of funding
- Public health prevention and population health management
- Locality diabetes model
- Outpatient transformation
- Support from specialists working at a locality level

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In Summary...

- Significant opportunity and investment
- Builds on our existing work and plans
- Developing PCNs within Locality Framework
- Recognise future opportunity for service transformation
- Workforce challenges