Exploring the early challenges facing Primary Care Networks

Survey of PCN Clinical Directors

BMA

Introduction

From April 2019 GP practices across England have been forming PCNs (primary care networks) – through which they will work together to provide care to populations of between 30,000 to 50,000.[1] It is hoped that over time with the right support, both nationally and locally, PCNs can have a positive impact for patients and general practice itself – through increased funding, expansion of the primary care team and by enabling primary care to have a stronger voice in local health systems.

Although PCNs are new, the idea of local GP practices working in closer partnership with each other and with other primary and community care staff has been developing for many years. Prior to the establishment of PCNs, many practices had already been working collaboratively. However, the formation of PCNs still represents one of the biggest changes in general practice for a generation, and it is vital that robust evidence is gathered as they begin to take shape.

In order to understand the situation on the ground the BMA has conducted a detailed survey of clinical directors across England, asking for their unique insights into how the process of embedding PCNs is going so far.[2] This report sets out the findings of this survey.

The BMA asked clinical directors about their experience being involved in the creation of PCNs, the recruitment of a new workforce, the delivery of new services and also their views on the future of PCNs.

The results reveal that whilst there is considerable optimism amongst clinical directors about what PCNs can achieve if given the resources, time and practical support to thrive, there are also concerns about the scale of the challenge facing these new structures and the expectations being placed on them. This has most recently been evident in the widespread serious concern raised following NHS England and NHS Improvement's publication of draft PCN service specifications.

Clinical directors have told us that PCNs alone cannot be expected to solve all the problems facing general practice and the wider NHS, at a time when health services across England are facing unprecedented pressures.

Although it is still too early to draw strong conclusions about the impact of PCNs, the findings of this report provide an insight into how they are developing so far. We are now at a crucial time in the development of PCNs, and it is vital they are given adequate funding, support with workforce recruitment, realistic goals, practical support and time to reach their potential.

---

1   With some flexibility on population size agreed locally
2   Fieldwork for the survey took place between October and November 2019. Approximately 20% of PCN clinical directors took part. The BMA intends to conduct the survey annually.

Key findings

— Most clinical directors (76%) said their PCNs contain at least some practices that have previous history of working at scale, although around a quarter (24%) said there were no prior arrangements.

— Clinical directors are broadly optimistic about what their PCNs can achieve if given the right support, with 63% saying they are confident in providing strategic and clinical leadership to their network.

— However, the results also show that PCNs and clinical directors need protected support and time to build their new primary care teams. Around half (49%) of clinical directors class their workload as unmanageable, whilst almost two thirds (63%) say the same about the workload of practices in their network.

— Most clinical directors (62%) told us they intend to still be in their role in 12 months' time. However, 27% said they were unsure, with 11% saying they don't plan to stay in the role.

— It is too early to reach conclusions about whether the formation of PCNs is having a positive impact in general practice, with 63% of clinical directors saying the impact so far on workload in their practices was neither positive nor negative.

— PCNs are already working closely with LMCs (local medical committees), with a majority of clinical directors saying they feel confident in developing relationships and working collaboratively with LMCs.

— However, clinical directors told us that relationships with Sustainability and Transformation Partnerships (STPs), Integrated Care Systems (ICSs) and local NHS trusts are currently much weaker, with 53% describing their relationships with their local ICS(s) or STP(s) as poor and 49% saying this about relationships with their local NHS Trusts.

— More than a third of clinical directors described the support offer they receive from their ICS/STP as poor, with 17% not aware that such an offer is available. It is therefore vital that STP and ICS plans, due to be published early this year, set out how they will work with and support PCNs.
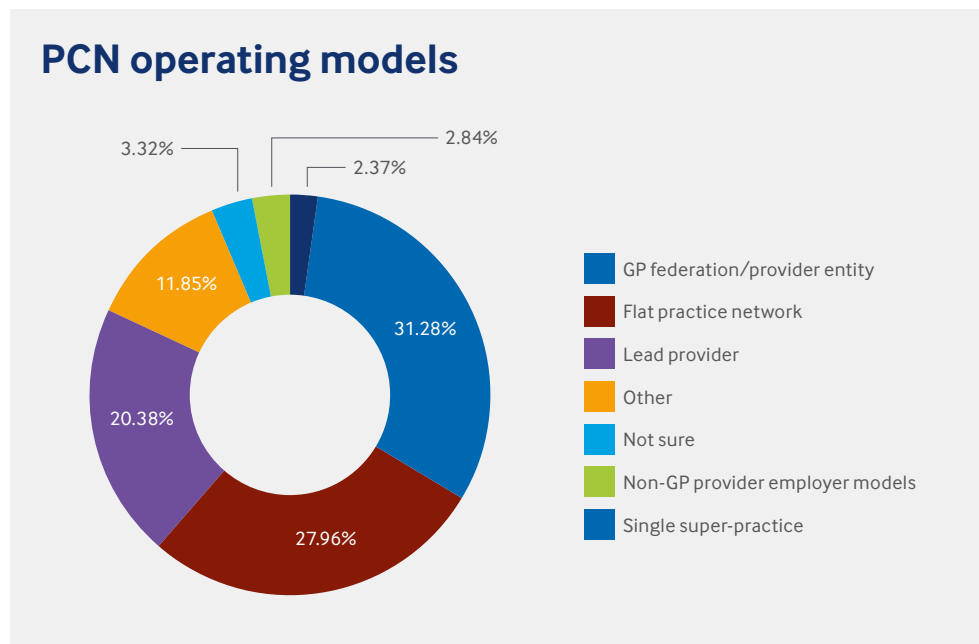
With the right investment and support, PCNs can form an important component of reinvigorating primary care as the bedrock of the NHS. However, there is also a real risk that clinical directors could withdraw from their roles and practices disengage with PCNs if they believe the workload and bureaucracy of involvement outweighs the benefit for their practices and patients. Drawing on the findings of this survey, and the recent feedback on the PCN service specifications, the BMA will engage with NHSEI to amend and improve the national contract in a way that works for clinicians working on the frontline in a fast-changing environment.

1. How are PCNs being set up?

A range of PCN operating models are being used

PCNs are taking a variety of different approaches to how they are structured. This means PCNs will take differing approaches to building relationship between participating practices, sharing funding and deciding where members of the extended workforce are employed and how any consequential liabilities sit.

The three main operating models being used by PCNs – GP Federation/Provider entity, flat practice network and lead practice model – represent almost 80% of all the PCNs whose clinical directors took part in our survey.

PCN operating models

Legend
GP federation/provider entity
Flat practice network
Lead provider
Other
Not sure
Non-GP provider employer models
Single super-practice

31% of clinical directors indicated that the operating model of their PCN was the **GP Federation or provider entity model**. Under this model, practices continue to employ their normal staff and provide their core GMS services, but the provider entity is subcontracted to deliver services required by the PCN DES (Direct Enhanced Service) and employ the range of necessary staff to do so. The GP Federation or provider entity is therefore responsible for all contractual arrangements and funding commitments, which helps reduce the liability on GPs and partners. Almost half (48%) of larger PCNs – those covering more than 60k patients – opted for this model. Most of these networks will cover the same geographic area as an already existing GP federation.

28% of the clinical directors indicated that the operating model of their PCN was **the flat practice network model.** Under this model, the network nominates a practice to receive the PCN funding as nominated practice payee, while responsibilities, contractual commitments and funding are spread across its members. All the practices have jointly signed up to a network agreement, which records the fact that all liabilities arising from the contracts relating to the functions and workforce are split between them.
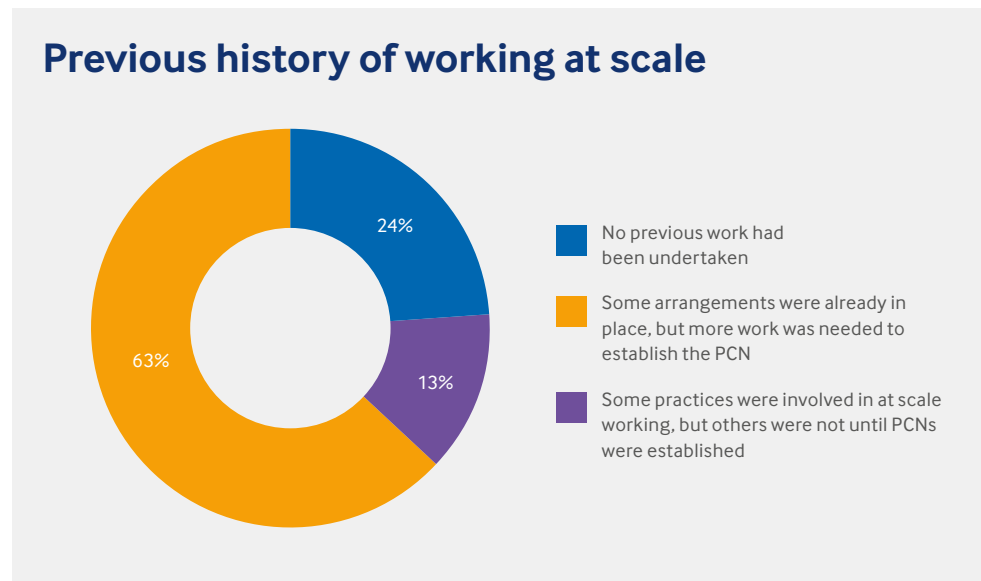
20% of clinical directors said their PCN chose the **lead provider model** as their operating model. Under this type of structure, the network nominates or identifies a lead practice which will not only receive the funding from the PCN but also become the focal point for engaging additional workforce and entering additional contractual arrangements on behalf of the PCN. In the previous model above, the contractual and funding commitments and responsibilities are split between all the practices. With this model, only provision of services flows to the network as a whole.

Most clinical directors (69%) said their PCN is not planning to change its operating model over the next 12 months, with around a quarter (23%) saying that changes may take place. This suggests that most PCNs are seeking stability and will focus on embedding the operating model they have chosen, but a significant minority may need support to make changes in the coming year

In the longer term, it will be important to evaluate the strengths and weaknesses of different operating models, to assess what different PCNs can learn from alternative approaches being taken by their peers.

Most, but not all, PCNs have previous experience of working at scale

Prior to the introduction of PCNs, most clinical directors said GP practices in their PCN had already been involved in a variety of approaches towards 'networked' or 'at scale' working.

Previous history of working at scale

- 24% No previous work had been undertaken
- 63% Some arrangements were already in place, but more work was needed to establish the PCN
- 13% Some practices were involved in at scale working, but others were not until PCNs were established
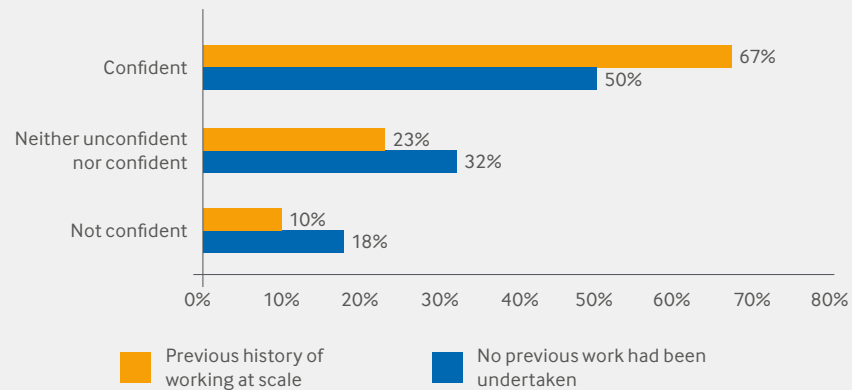
A majority of clinical directors (76%) said their PCN includes practices with some pre-network arrangements in place or were involved in at scale working prior to the introduction of PCNs in April 2019. A quarter of clinical directors (24%) said that practices in their PCN had no previous history of working at scale before PCNs were established.

It is reasonable to assume that where a history of working at scale exists, PCNs will be able to draw on some advantages in terms of being able to build on existing relationships and shared resources. Although more research is needed, our initial survey findings appear to support this.

Clinical directors who work in PCNs which had pre-existing at scale working arrangements are more likely to say that their they are confident in providing strategic and clinical leadership to their network with 67% saying this compared to 50% in PCNs which have no history of working at scale.
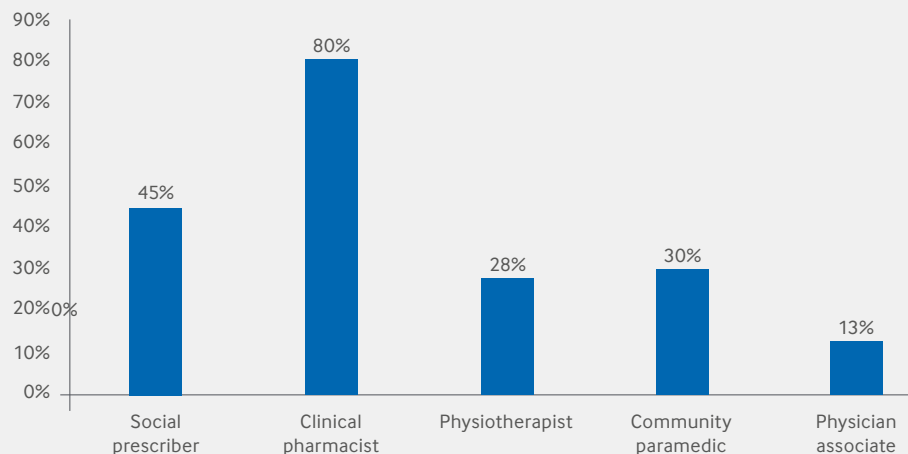
Clinical director's confidence in their ability to provide strategic and clinical leadership based on previous history of working at scale across their PCN

Legend: Previous history of working at scale | No previous work had been undertaken

- Confident: 67% / 50%
- Neither unconfident nor confident: 23% / 32%
- Not confident: 10% / 18%

Most PCNs have experience in multi-disciplinary working

The majority of clinical directors told us practices in their PCN have a history of multi-disciplinary working involving at least some of the wider primary care team PCNs are being encouraged to work with.

Access to allied healthcare professionals prior to the establishment of PCNs

- Social prescriber: 45%
- Clinical pharmacist: 80%
- Physiotherapist: 28%
- Community paramedic: 30%
- Physician associate: 13%

Almost half of clinical directors (45%) told us their PCN includes practices that provided access to a social prescriber prior to the establishment of PCNs and 80% said practices had previously provided access to a clinical pharmacist. The high number of clinical pharmacists who had already been working in GP practices prior to the establishment of PCNs is a testament of the success of the Clinical Pharmacists in General Practice Programme which ran from 2015-2019.
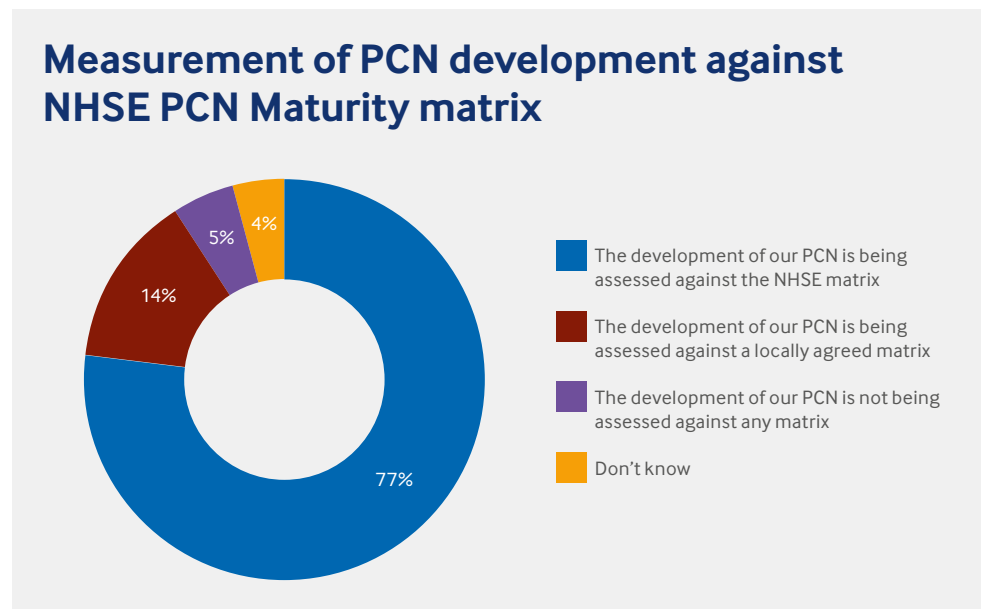
Almost a third of clinical directors said practices in their PCN had provided access to a physiotherapist (28%) and to a community paramedic (30%) prior to the establishment of PCNs.

Only 13% of PCNs have member practices that provided access to a physician associate before PCNs were established.

These findings indicate that in many PCNs the additional roles have already been tried and tested in General Practice before the introduction of PCNs. This reinforces the idea that the extension of the primary care team can potentially be valuable to GP practices in terms of controlling GPs' workload and improving patient access and care. Funding for pre-existing initiatives should continue to ensure learning from these is not lost.

Most PCNs are using NHS England's 'maturity matrix' to track their progress

NHSE has designed a 'maturity matrix' which it is encouraging PCNs to use to assess the progress of their networks and provide direction for their development.

Measurement of PCN development against NHSE PCN Maturity matrix

- The development of our PCN is being assessed against the NHSE matrix
- The development of our PCN is being assessed against a locally agreed matrix
- The development of our PCN is not being assessed against any matrix
- Don't know

77% of clinical directors said their PCN is using NHSE's matrix while 14% measure their development through a list of criteria set out in a locally agreed matrix. Just 5% said their PCN's development was not being assessed against any matrix.

The BMA is concerned that 52% of clinical directors told us the completion of a maturity matrix was a condition of receiving support or resources from their local STP/ICS. The matrix should not be used in this way and could cause unnecessary delays in PCNs securing the funding they need.

Some clinical directors expressed concern about the accessibility of the matrix itself:

"The matrix from NHSE is in a language that most clinicians can't relate to."

2. How are clinical directors settling in their new role?

Clinical directors are broadly confident they can have a positive impact

Networks have appointed over 1,250 clinicians as clinical directors, and agreed the role, responsibilities and accountability criteria for these local leaders who will contribute to the delivery of the network contract specifications.

Many clinical directors who took part in the survey said they feel confident that they can have a positive impact on the development of their network and the building of excellent relationships across their local primary care team and health and care organisations.

Most clinical directors (63%) said they feel confident in their ability to provide strategic and clinical leadership to their network, with 64% saying they feel confident in their ability to influence, lead and support the development of excellent relationships across the network.

In addition, 72% say they're confident in their ability to develop relationships and work collaboratively with colleagues in their LMCs.

Are you confident in your ability to...

	Not confident	Neither confident nor confident	Confident
Providing strategic and clinical leadership to the network	12%	25%	63%
Influencing, leading and supporting the development of excellent relationships across the network	10%	25%	64%
Developing relationships and collaboratively working with colleagues in your local medical committee	7%	20%	72%

But clinical directors say their workloads are currently unsustainable

Given the very important role they will play in the success of PCNs, it is very concerning that many clinical directors told us that their workload is unmanageable.

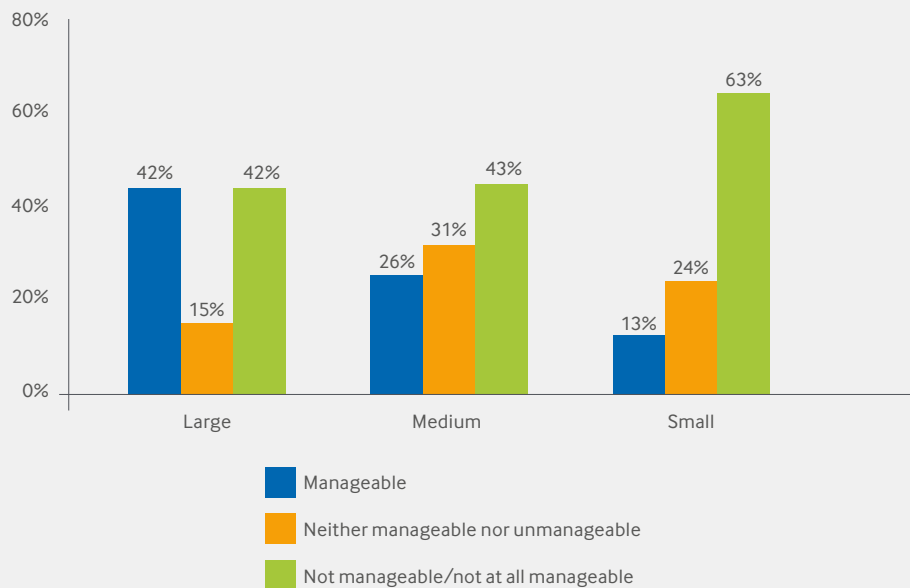## PCN clinical directors' workload
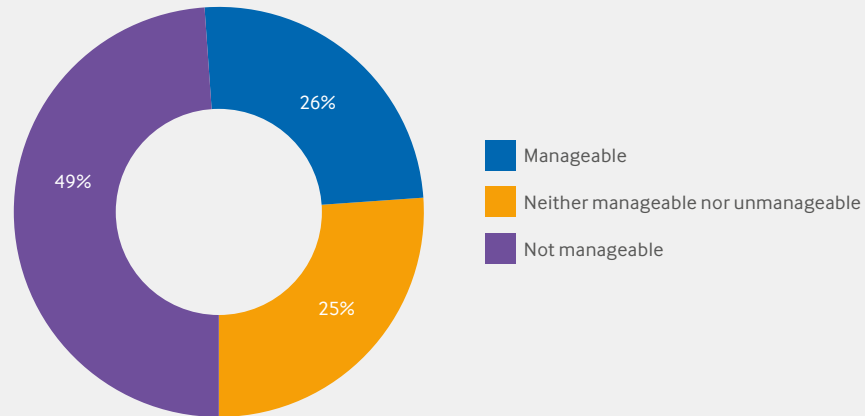
Almost half of clinical directors (49%) indicated that their workload was not manageable. Some told us that that the level of expectation placed on them, and the time and funding allocated to perform their role, were simply not sustainable. Many said this was frustrating because they felt otherwise confident and enthusiastic about their new role.

Examples of feedback include:

"My concern going forward is the sheer volume of time and work involved in being a clinical director and the lack of specific management funding for the PCN to facilitate the work."

"The amount of work required is nowhere near met by the clinical director reimbursement. Our CCG is permanently in deficit and is therefore actively trying to renege on funding commitments. We have great ideas but cannot work at the pace we want."

PCN clinical directors' workload based on PCN size

There appears to be a relationship between PCN size and how manageable clinical directors feel their workload is. Clinical directors who work in smaller PCNs (<40,000 patients) are less likely to say that their workload is manageable, with only 13% saying this compared to 26% for in medium (<40,000-60,000< PCNs) and 42% in large PCNs.
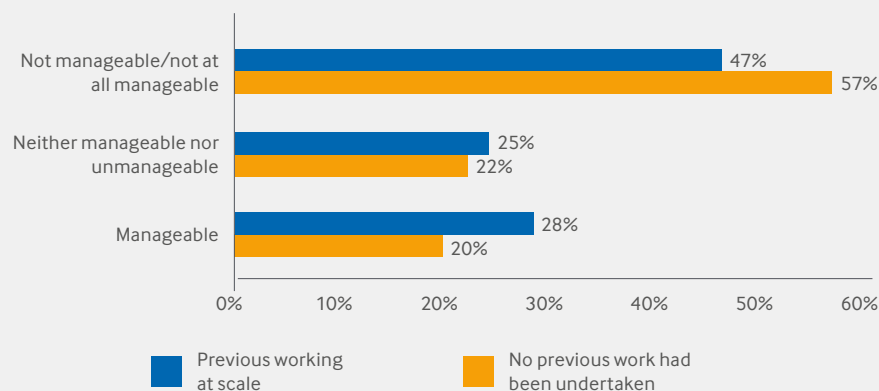
One clinical director indicated that they felt that bigger practices with a history of working at scale were in a better place to implement the PCN DES.

"I feel the network DES favoured practices that were already federated [or] merged. It has left smaller, independent practices at a significant disadvantage."

Less than six months after the establishment of PCNs, clinical directors are still settling into the role, contributing to the recruitment of additional roles for the network and building relationships with other primary care organisations and wider NHS system, which may also be adding to their workload level. It is vital that at both a national and local level clinical directors are supported to reduce this workload to sustainable levels.

Clinical directors who work in PCNs which had pre-existing at scale working arrangements are marginally more likely to say that their workload is manageable with 28% saying this compared to 20% in PCNs which have no history of working at scale. However, more research is needed to understand this.

Clinical director's workload based on previous history of at scale working

	Previous working at scale	No previous work had been undertaken
Not manageable/not at all manageable	47%	57%
Neither manageable nor unmanageable	25%	22%
Manageable	28%	20%

Although most clinical directors (62%) intend to still be in the role in the next 12 months, it is worrying that a significant minority are unsure about this or planning to leave their role.

Intention to stay in the role in the next 12 months

Response	Percentage
Yes	62%
No	11%
Don't know	27%
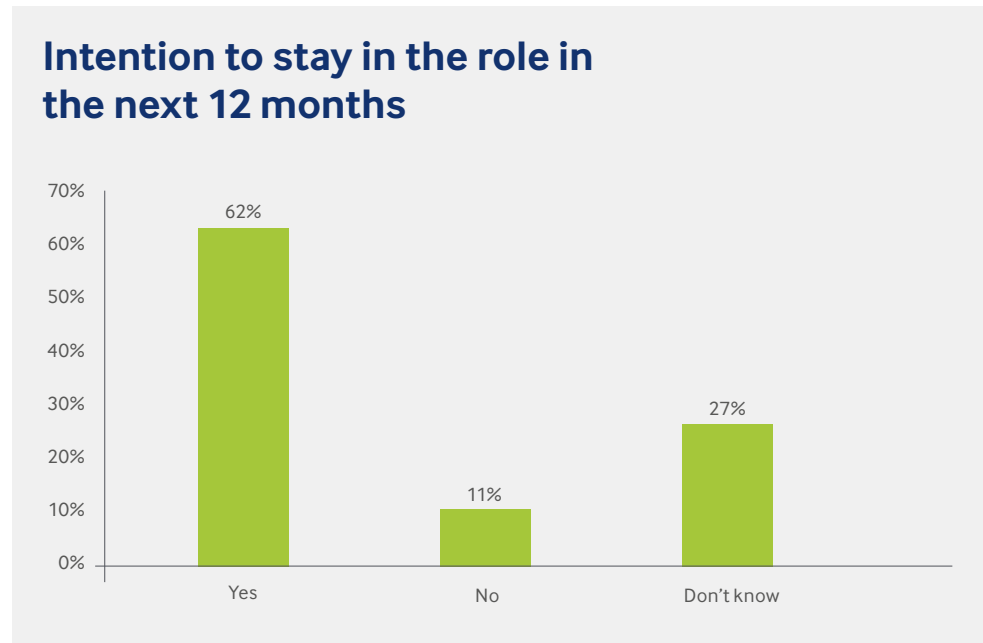
3. What impact are PCNs having on practice workload?

PCNs were introduced in a context of overall unprecedented levels of pressure for general practice and the whole NHS. Through increased resources, more integrated working, mutualisation of resources and new ways to respond to a growing patient demand, it is intended that over time PCNs will help reduce practices workload to more sustainable levels.

We asked clinical directors to assess the impact they've had so far on their member practices' workload. Given that PCNs are less than a year old, these findings provide a baseline from which we hope to measure future changes — clearly not enough time has passed to expect a significant impact to have occurred yet. The results reveal that the starting point for most PCNs is that their practices currently have a very high level of workload.

Member practices' workload

14%
22%
63%

- Manageable
- Neither manageable nor unmanageable
- Not manageable
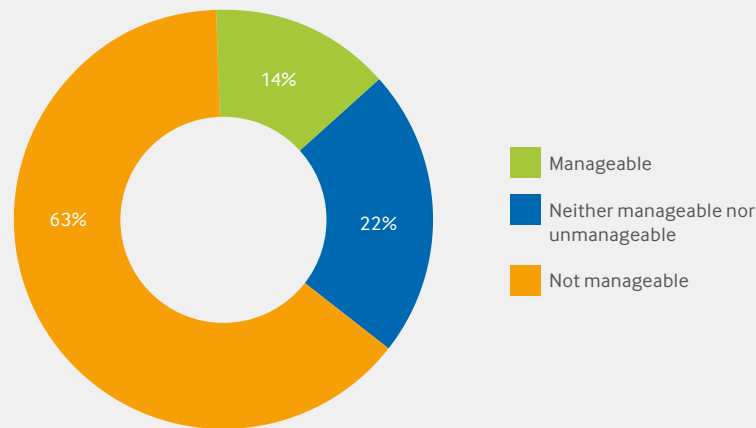
Unsurprisingly, a majority of clinical directors (63%) said it is still too early to say whether the impact of PCNs on their member practices has been either positive or negative.

Impact of PCN on member practices' workload

10%
27%
63%

- Negative
- Neither negative nor positive
- Positive
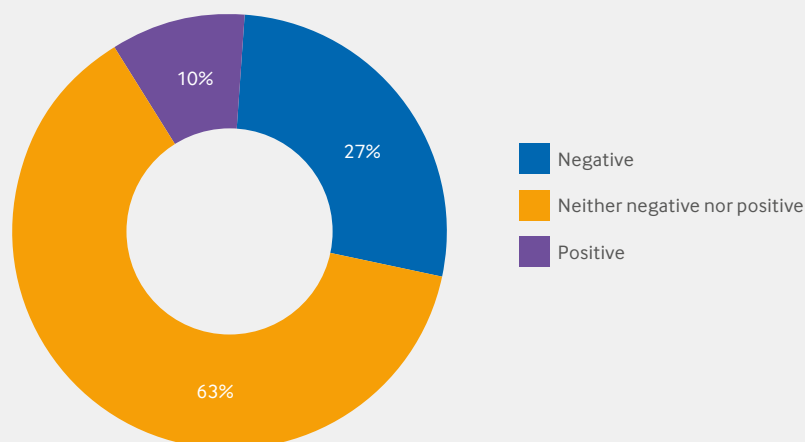
PCNs are still at too early a stage of their development to have had any significant impact on the member practices' workload. The network set-up, the recruitment of the additional roles, and the preparation of the delivery of new services through the network, may have contributed to increase the workload over the last few months.

But overall practices struggling with overwhelming workload are facing more fundamental issues around workforce capacity and lack of investment.

While some results suggest that embedded working at scale can have a positive impact on workload, provided sufficient time and support is offered, it is important to keep realistic expectations for what PCNs can achieve in such a short time.

### PCNs are extending their workforce and recruiting for additional roles.

Over the coming years, as PCNs develop, their member practices will be supported in building an expanded primary care team to help alleviate workload pressures. While the engagement of additional staff is not a requirement of the DES, an expanded primary care workforce will be necessary in order to undertake elements of the scheme as it is expanded over the coming years.

Following the establishment of their structure of governance, PCNs have this year started the recruitment of clinical pharmacists and social prescribers.

For the first year of the DES (2019/20), every network with a population of at least 30,000 can claim 70% funding for one additional WTE (whole time equivalent) clinical pharmacist and 100% funding for one additional WTE social prescribing link worker.

Over the coming years, first contact physiotherapists, physician associates and community paramedics will all be added to the scheme too and the workforce reimbursement system will be altered so that it is linked to the patient population of the PCN.

At the time when the survey was conducted, a majority of the networks were still in the process of recruiting for these additional roles.

Reimbursement for additional roles
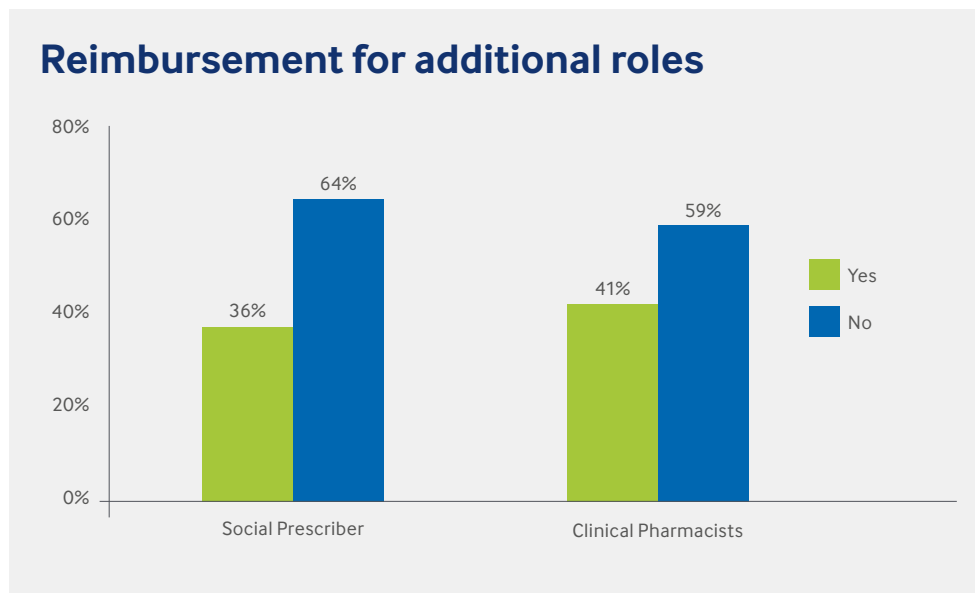
36% of clinical directors indicated that their network was receiving reimbursement for the social prescriber role and 41% indicated that their PCN was receiving reimbursement from their CCG for the clinical pharmacist role this year.

Ongoing recruitment processes seem to be the main reason to explain the current low levels of reimbursement for the additional roles. Almost a third of clinical directors (26%) indicated that their PCN was not receiving reimbursement for these additional roles yet, as they had not been able to complete the process of recruitment of candidates when the survey was conducted.

The main difficulty that networks are facing in trying to recruit for these roles is linked to the limited availability of sufficiently trained or qualified candidates.

Clinical directors have also highlighted the insufficient funding for activities linked to the management, development and training of these additional roles. One clinical director said:

"There is an inadequate provision of funding to support the training of the Additional Roles. There is no funding available either to support the management of these Additional roles."
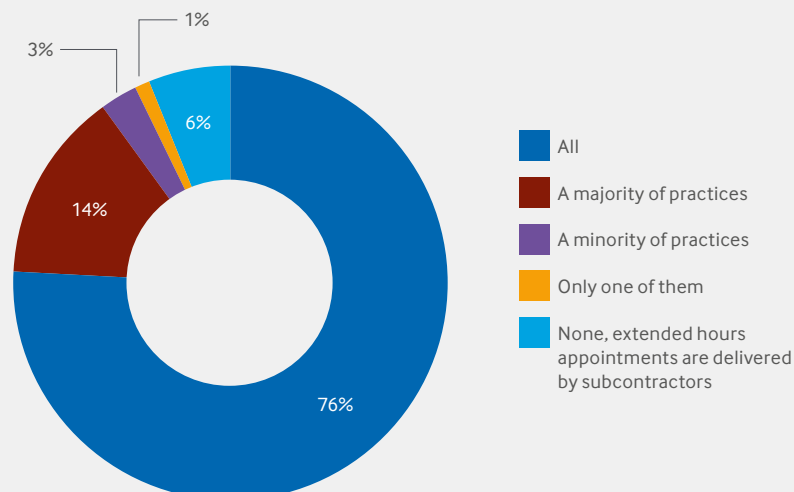
Networks are now responsible for extended hours appointments

Since July 2019 the Extended Hours DES requirements and funding have been transferred into the network contract. From 2021, this will be combined with the Improving Access funding which is a significant resource.

PCNs should be given flexibility about how this new funding is best used, including providing greater opportunity to take pressures of day-time practice appointments and improve access to services such as childhood and flu immunisations, smears, long-term condition annual reviews.

Clinical directors are telling us that in most cases all practices of the network contribute to the delivery of extended hours appointments, and 80% of clinical directors say that in their PCNs the majority of extended hours appointments are being taken up.

How many practices in your network are delivering extended hours appointments as required by the new DES?

- 76% — All
- 14% — A majority of practices
- 3% — A minority of practices
- 1% — Only one of them
- 6% — None, extended hours appointments are delivered by subcontractors

76% of clinical directors said their PCNs have arranged for all practices to provide access to extended hours appointments, with 14% indicating that a majority of practices but not all, provide access to those type of services.

We asked clinical directors about which health professionals were providing appointments as part of the extended hours services.

40% of clinical directors said that in their PCNs, the provision of the extended hours appointments as set out by the DES is shared equally by the GPs in the member practices and the other health professionals hired by the network.

36% of clinical directors have also indicated that in their networks, a majority of extended hours appointments were provided by GPs, and a minority by health professionals.

Clinical directors have indicated that a significant majority (84%) of the extended hours appointments available are being taken up by patients since the establishment of PCNs.

Which of the below statements best describe the situation in your PCN?
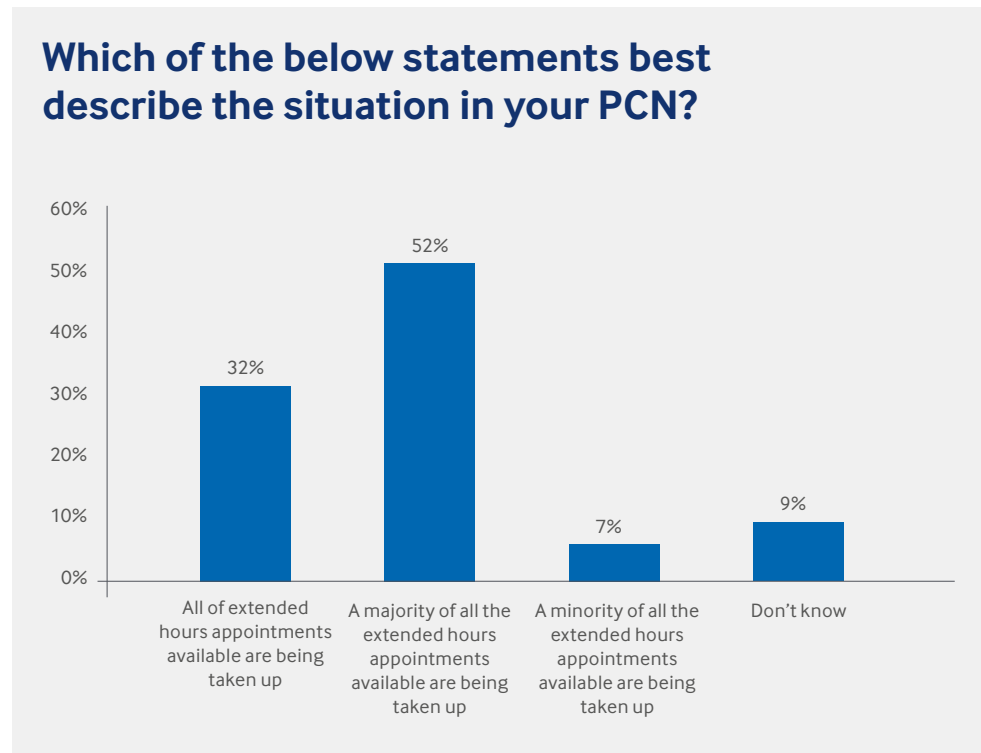
4. How are PCNs developing relationships with the wider NHS?

Clinical directors and PCNs have potential to strengthen the voice of general practice within the wider system and at regional level. The new networks will need to develop strong relationships with other primary care organisations and counterparts across their local systems to achieve the ambition of making general practice more sustainable for the future.

At such an early phase of the development of their networks, clinical directors have told us that they feel they have reasonably strong relationship with their local LMCs and CCGs, but that there is more work to do to develop the same kind of partnerships with their STPs, ICSs, local NHS Trusts and Local Authorities.
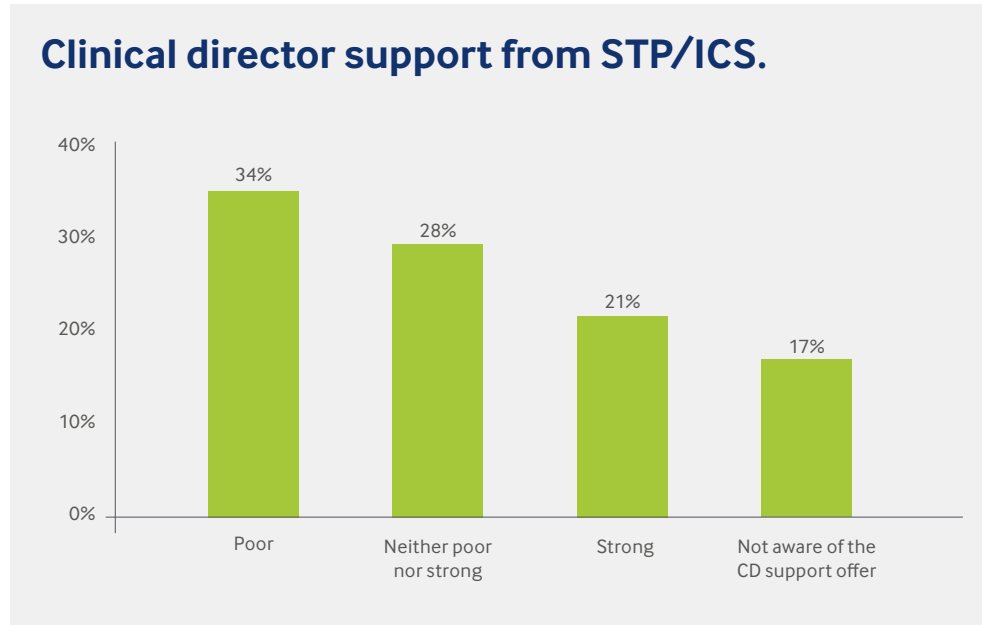
Relationship with external stakeholders
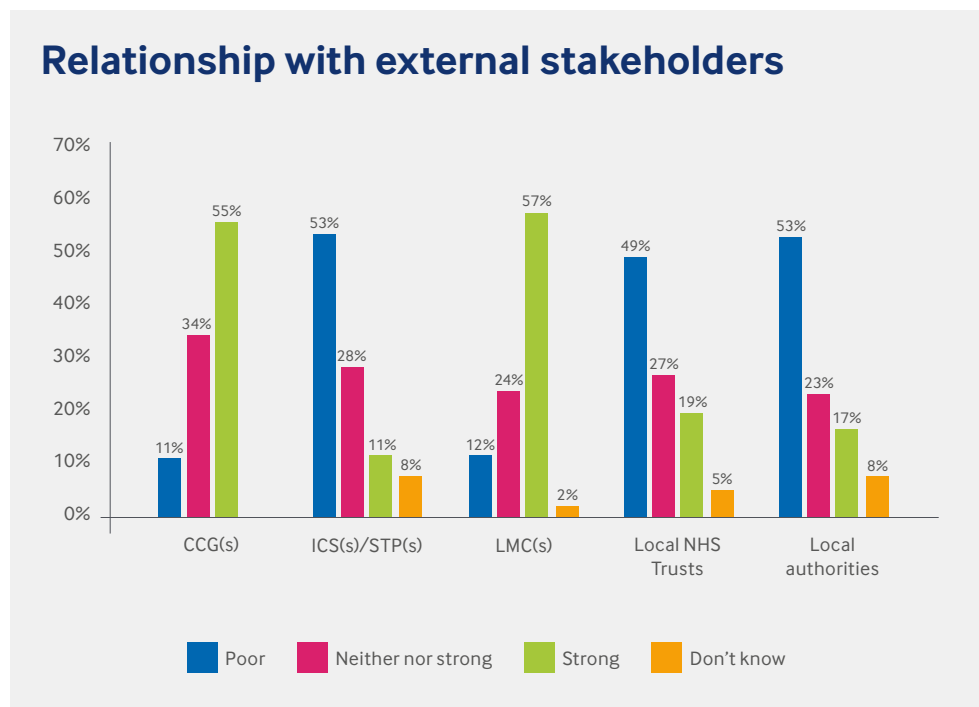
55% and 57% of clinical directors described their relationships with their CCGs and LMC(s) respectively as strong. However, 53% described their relationships with both their ICS(s)/STP(s) and with Local Authorities as poor, and 49% described relationships with local NHS Trusts as poor.

More than a third (34%) of clinical directors told us that the support offer they receive from their ICS/STP is either insufficient or not tailored to their needs, with 17% not aware that such an offer is available. Even at such an early stage in their development, this is a stark and concerning result which strongly indicates that there is much STPs and ICSs can do to support these leaders in their new roles. The forthcoming STP and ICS plans – expected to be published early this year – are a vital opportunity for progress to be made in this area.

As PCNs develop STPs and ICSs must engage them and give them a voice in their decision making, particularly in their approach to supporting and strengthening primary care.

34% of clinical directors told us that the support they receive from local STPs/ICSs is currently poor, while 17% were not aware of clinical director support available to them. As their relationships grow through the development of PCNs, clinical directors will need to receive improved support more tailored to their needs.

Clinical director support from STP/ICS.

Category	Percentage
Poor	34%
Neither poor nor strong	28%
Strong	21%
Not aware of the CD support offer	17%

5. How can PCNs be supported?

We asked clinical directors about their confidence in the future success of PCNs and about the key factors that would contribute to that success. The results show that overall levels of confidence are quite low at this stage, and that clinical directors feel more funding and an increased GP workforce are the most important factors in deciding whether PCNs will succeed.[3]

Confidence in the success of PCNs
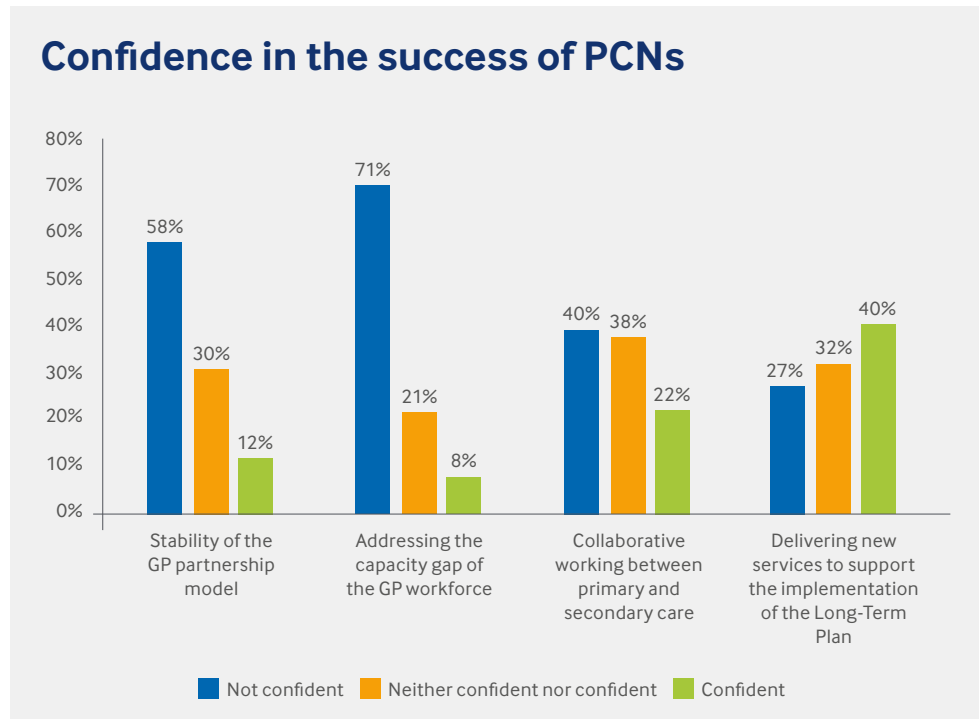
40% of clinical directors are confident that their network will contribute to the delivery of new services to support the implementation of the Long-Term Plan.

However, as this early stage of development of their networks, clinical directors are not confident that the reorganisation of primary care as supported by the PCN DES will either contribute to the stability of the GP partnership and or addressing the capacity gap of the GP workforce.

These results reflect the fact that as they form, PCNs are already facing considerable pressures. With general practice and the NHS as a whole dealing with workforce shortages and overstretched funding, it is unsurprising that many clinical directors feel concerned about the future. Achieving lasting change in an organisation as complex as the NHS will always be difficult but trying to do this whilst also keeping services afloat is particularly challenging.

3   The survey was conducted before the publication of the service specification and it is very likely that the results to these questions would be significantly worse if asked at the time of publication.

A recent 'pre-mortem' report from the Nuffield Trust on PCNs argued that there is a risk that they "could become overwhelmed by external pressure" and also that "failure could be unfairly identified too early"[4]. These findings must therefore be viewed both in the context of these external pressures, and as 'benchmarking' research conducted at the outset of the implementation of PCNs.

PCN clinical directors were asked to rank by order of preference the options which they feel would most contribute to the future success of their network.

What do you think PCN need most to succeed?
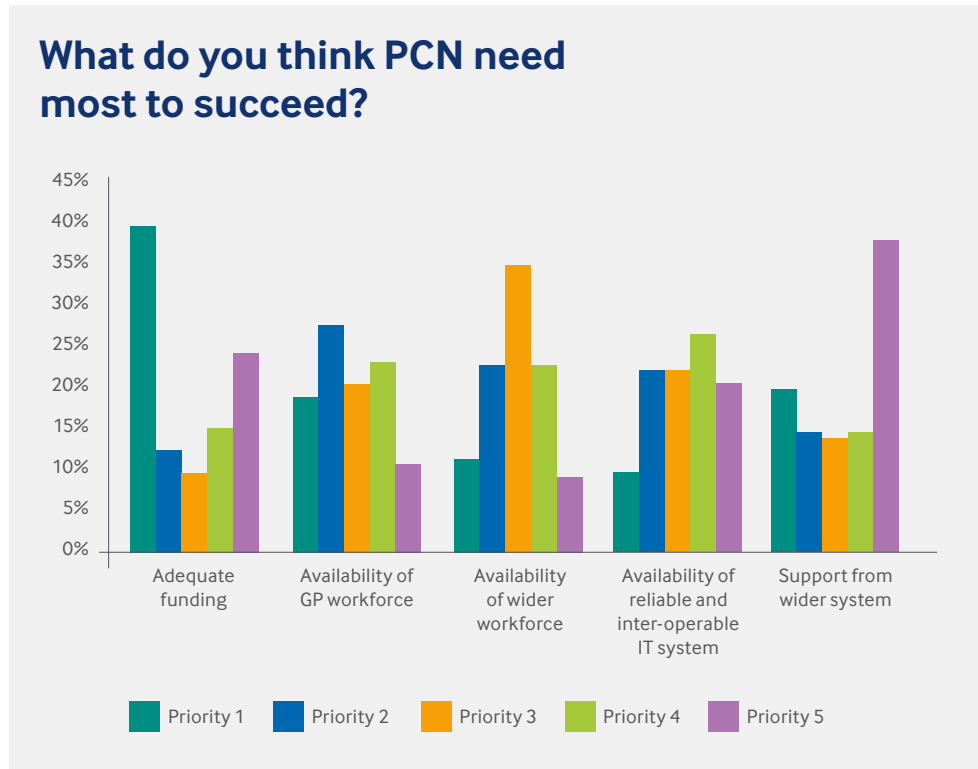
	Priority 1	Priority 2	Priority 3	Priority 4	Priority 5
Adequate funding	**39.29%**	12.24%	9.69%	14.80%	23.98%
Availability of GP workforce	18.56%	**27.32%**	20.10%	23.20%	10.82%
Availability of wider workforce	11.05%	22.63%	**34.74%**	22.63%	8.95%
Availability of reliable and inter-operable IT system	9.64%	21.83%	22.34%	**26.40%**	19.80%
Support from wider system	19.70%	14.29%	13.79%	14.29%	**37.93%**

Most clinical directors indicated that the provision of adequate funding was the most important condition for the success of PCNs. The second mostly highly ranked option was the availability of GP workforce, followed by the availability of wider workforce.

This was also reflected in some of the written feedback we received from clinical directors:

"PCNs are designed to make general practice sustainable but they can only do that if there is adequate GP numbers and the additional roles are 100% funded. PCNs are being hijacked by CCGs expecting us to collaborate and move more work out of secondary care when we cannot manage the workload we have currently."

4   Nuffield Trust (2019), Primary Care Networks: a pre-mortem to identify potential risks

"It is very early in the delivery phase of PCNs. The wider system considers the ARRS [additional roles reimbursement scheme] to be part of the solution to community services and we are faced with ensuring that new services do not remove this resource that strategically is designed to stabilise primary care. We have promising staff within PCN that are developing the operation and strategic arms. Better than where we have been, but we haven't delivered yet for our member practices (staff and patients).

"We feel that the network DES is all very prescriptive and provides little opportunity to do what we may want to do."

Some clinical directors also told us that they were concerned about issues around practices within PCNs having to take on increased employment and VAT liability – concerns around which the BMA has raised with NHS England.

"Need clarity on the long term future of PCNs, otherwise fear of employment liability will impact upon recruitment."

"The legal and financial issues in the set up of PCNs need urgent resolution. VAT and employment risk continue to be a deterrent for some practices to fully commit in spirit to the idea of joined up working."